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1. Howard, J. E. Protein Metabolism During Convalescence After Trauma. Arch. Surg. 50:166, 1945.

2. Co Tui, Minutes of the Conference on Metabolism Aspects of Convalescence Including Bone and Wound Healing. Josiah Macy, Jr. Foundation, Fifth Meeting Oct. 8-9, p. 57, 1943.

3. Whipple, G. H. and Madden, S. C. Hemoglobin, Plasma Protein and Cell Protein: Their Interchange and Construction in Emergencies. Medicine 23:215, 1944.

4. Mulholland, J. H., Co Tui, Wright, A. M., Vinci, V., and Shafiroff, B. Protein Metabolism and Bed Sores. Am. Surg. 118:1015, 1943.



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Opinions From Here and There

**Prepared for your information by the Committee on Public Policy and
Legislation of the Indiana State Medical Association**

Get out the aspirins, as it looks like they are going to be needed come the 1953 session of the Indiana State Legislature. The legislative committee urges the members to have their vitamin shots and all other known "pep-er-uppers" handy for a quick injection of those who will attempt to keep track of the legislative goings-on.

* * * * *

It's too early to be certain on making predictions on just what is going to happen. From the editor's chair it looks like the coming session will have its problems, and some of them may catch the profession in the middle.

* * * * *

Profession confronted with much proposed legislation which would affect the practice of medicine one way or another. At this writing it appears the session will be flooded with legislation touching upon the practice of medicine.

* * * * *

Chiropractors to be in full bloom again, according to reports received. We have been informed that a big push is to be made in the coming session to ram legislation through creating their own board. We hope that every physician is ready to assist if the going gets tough.

* * * * *

Workman's compensation bill will be a hot one, according to present cloakroom conferences, and both sides are trying to woo medicine to their way of thinking. Labor forces, who will sponsor the bill, feel the profession should align itself with their side because we opposed socialized medicine because it eliminated "free-choice" of physician, and the proposed change in the law guarantees "free-choice" to laboring people covered by compensation insurance.

* * * * *

Present bill permits employer who pays total bill for insurance to select the physician to treat injured employees under the compensation act. Management, through the Chamber of Commerce and the insurance carriers, all argue this is as it should be, because (1) Management pays the total bill, therefore it should have the right to name the physician; (2) Industry has made forward strides in caring for injured employees, and any change in the act would tend to slow down further advancements in this field, and (3)

There is nothing to prevent the employe from having his personal physician consult on his care.

* * * * *

Principles of medical ethics of the AMA indicate that when a third party pays for the care, the third party has the right to select the person to render the care.

* * * * *

Governor Craig is on record as favoring the move of labor to secure legislation permitting "free-choice" of physician in cases of injury. This would mean that an employe who is injured on the job would have the right to go to any physician of his choice for treatment and the employer or the insurance carrier would necessarily have to pay the charges for this service, even though not rendered by their company physician.

* * * * *

There could be a joker in this legislation, unless a definition is clearly made limiting those who may provide this care to duly licensed physicians of medicine and surgery. Otherwise the insurance carriers would find themselves in the position, perhaps, of being forced to pay cultists for treatment and care.

* * * * *

Recommendations of "Little Hoover Commission" which were made as a result of a study by a bipartisan committee of the 1951 Legislature, in which they recommend changes in the licensing boards of the state, raise a large question in the minds of many. The report, together with newspaper stories, indicate there will be an effort made to consolidate the boards under the direction of a single administrator.

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Such a move poses many problems that might have far-reaching effects upon the practice of medicine.

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It has been recommended that the Medical Board as well as all other licensing boards, together with the Board of Health and other departments of State Government, be lumped under the Department of Commerce, whose Director would be a member of the Governor's Cabinet. Thus, all such departments and boards would be under the Director of the Department, rather than being responsible to the Governor as is now the case.

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Under the proposal the Board's authority would be questionable. The big question is, will they retain their administrative functions or will they become strictly advisory?

Some believe the intent is to remove the authority of the Boards in administering their laws, while some say that is not the intent. Those who believe the Boards will be stripped of their administrative functions, see the move as one which will bring chaos and inefficient administration of the various laws, and a loss of the Boards' authority to police the professions for which they have been responsible for licensing. The other side sees the move as purely one of economy in which the Boards will be consolidated for the purpose of staff efficiency only, in which a common pool of stenographers and investigators would be utilized which in no way would disturb the present authority of the Boards.

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It remains to be seen just what, if anything, is recommended in the way of legislation or executive order to change the present system. It is something every physician should watch, to prevent any move being made which might incapacitate the Board authority over licensing and policing their areas of responsibility.

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"Lobby" in a Gold Fish Bowl. That's the title of a pamphlet issued by the Indiana State Chamber of Commerce, which is acting as a coordinating agency for the statewide Citizenship Participation program of 214 Indiana organizations "working together for good government in the state." The Chamber says the program may be the means of creating interest in greater participation in government by "we the people." They'll issue a series of leaflets on issues in the fields of State Taxation and Finance, Unemployment Compensation, Public Welfare, Personnel and Labor Relations, etc., then follow up during the legislative session of the Indiana General Assembly with brief digests of bills introduced and will report daily action on all bills. There are few bills which will be introduced which will not affect medical doctors in some way—either as private citizens or as members of a skilled and honored profession.

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National

Prospects on Capitol Hill. It is idle to speculate on nature of health legislation to which the new 83rd Congress will pay the most attention in 1953 and 1954. However, there is little hazard in assuming that consideration of doctor-draft law will be taken up early. More generally speaking, one may anticipate introduction of fewer "fringe bills" than has been the case in previous years—bills on Federal support of public health agencies, medical schools, consumer-operated health cooperatives, etc. Reasons: (1) All these cost money, lots of money, and new leadership will be extremely budget-conscious; (2) Democrats, in past, have been principal pushers and now they're the minority party; (3) acceleration of voluntary effort toward improvement of prepaid medical and hospital care plans and self-help financing of professional education has diluted arguments for Federal intercession.

Although establishment of a Department of Health seems more remote than ever, Congress may look with favor on money-saving coordination of government's various medical services. It is likely to extend Hill-Burton hospital construction act, whose expiration date is not far distant. Economy may dictate a belt-tightening on financial support of medical research, but nothing drastic is expected.

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House Medical Bloc Shrinks. In House of Representatives, M.D.'s who'll be back are Judd (R., Minn.), Morgan (D., Pa.), Miller (R., Neb.), and Fenton (R., Pa.). Hedrick (D., W. Va.) made an unsuccessful bid for gubernatorial nomination, giving up his House seat. Wood (R., Idaho) was defeated for re-election. House roster loses two dentists and gains one. Departures are Woodruff (R., Mich.) and Brehm (R., Ohio), both of whom retired. The addition is Long (D., La.), brother of Huey Long and uncle of Senator Russell B. Long. In the other branch of Congress, sole representative of the health professions continues to be Senator Lester C. Hunt, a Democrat, who has been elevated to rank of senior Senator from Wyoming as result of O'Mahoney's defeat. Note: Among physician-legislators, only Dr. Miller takes more than a casual interest in national health legislation.

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Medical Veterans Society Decidedly Active at Birth. Although it was organized—on a national basis—only last week in Toledo, the Medical Veterans Society already is an influence to be reckoned with in connection with administration of present doctor-draft law and forthcoming consideration of same by Congress. A legislative committee has been formed, a carefully executed revision of physical standards for medical officers has been submitted to Washington for consideration, plans are under way for participation in AMA's next meeting in New York six months hence.

Meantime, Department of Defense has placed a large order, for February delivery, with Selective Service—537 physicians and 286 dentists. Army is to get 337 physicians and 241 dentists, with Air Force receiving 200 and 45, respectively.

—Gerald G. Gross.

* * * * *

Make No Deferments for Residencies—Draft Memo. Local medical advisory committees to draft boards are being advised by Washington to extend no deferment, for purposes of residency training, to special registrants in Priority III who are in younger age groups. They should be listed as available for military service as soon as they have completed internships, according to a memorandum dispatched recently by National Advisory Committee to Selective Service System. Hospitals, it says, should fill residencies from: (1) Priority IV's (veterans, who are estimated to constitute about 80 per cent of current interns); (2) physicians in process of being discharged from military duty; and (3) women and other physicians who are not obligated under doctor-draft law.



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Cost Allocations Of Overtreatment Dermatitis

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Evansville

AT A TIME when the high cost of medical care is threatening our system of practice; when hospitals have raised their rates; when Blue Cross has increased premiums; when the American Medical Association has asked us to display a placard to invite discussion of services and fees with patients; when the trend to government regulation of medicine must be faced; it is opportune to look for ways to reduce the cost without affecting the quality of medical care. Overtreating, and overdrugging, of patients is as great an evil as inadequate treatment. Economic vigilance is needed in order to maintain the integrity of our system from within and prevent undermining from without.

To be explicit, an example is cited. A mother had recovered from a severe therapeutic dermatitis. It developed after using an antipruritic cream to stop the itching of an eruption on the right hand. She had spent six days in the hospital. The duration of the post-treatment patch test reaction¹ to the remedy was being recorded. She offered this comment, "Why do you doctors allow people to buy medicines that instead of getting us well, put us in the hospital. My skin trouble cost us over \$200, and if it had

not been for Blue Cross we would be in a fix." These comments by patients are being heard more frequently. The agitators have pushed these complaints into public view with a cry that "a change is needed." Is there such a dearth of therapeutic agents that poorly-controlled treatment results are sufficient evidence to sample and reprint the drug to every doctor in the country? Cost increments—drugs and administration—from inadequately studied and worthless therapies have been placed on our doorsteps by the opportunists.

Method of Obtaining Statistics

Early in the spring of 1952 the incidence of contact dermatitis was studied in dermatologic patients. Only a trend was desired in order to keep the figures as simple as possible. The time period was 6 weeks. In this interval and season 30 per cent of new patients had clinical evidence of eczematous contact dermatitis. This figure is probably high. Any patient with a non-specific eruption that involuted when suspected contactants were removed was classed as contact dermatitis. A patient with occipital eczema who used raw egg shampoo, stopped all cosmetics, eliminated other suspected irritants, and gradually

* Doctor Underwood died November 10, 1952.

got well was included. Pedal eruptions that healed after wearing all leather sandals were included. Patch tests confirmed the etiology in many of the cases.

Every patient with an established diagnosis of contact dermatitis, and who had had previous topical therapy, was asked to bring in all the remedies they had used. These were lined up on a table before the patients, and their sequence of application recorded. Dates on prescriptions were of great help. The onset, etiology and course of the dermatitis was then correlated with the sequence of topical therapy. When the acute stage of the dermatitis had passed, past-treatment patch tests were performed. As a rule the severity of the patch test reactions to the remedies followed closely the course of the dermatitis. Patients enthusiastically noted, "I had a breaking out on my finger here for several months. It would get better then worse. When I used the fourth tube of salve there on the table, it seemed to do a lot of good at first; and then all at once it got worse." Past-treatment patch test reactions proved that in 27 per cent of patients with contact dermatitis, minor or severe complications were produced by topical treatments. Four patients with obvious evidence of overtreatment refused patch tests. Including these cases would have increased the incidence to 30 per cent. An organomercurial was the etiology in 4 cases; Pontocaine and Nupercainal, 1 case; Calgesic, 3 cases; Rhulitol, 2 cases; Ivy Dry, 1 case; ammoniated mercury, 1 case; Jergens Lotion and Mede-X, 1 case; and unknown prescriptions, 4 cases.

The histories in the 17 overtreated cases showed the usual series of events 2, 3, 4, 5, 6. Wives or husbands, fathers or mothers, relatives and friends, and mere acquaintances, and lay-diagnosticians, including hawkers, treat the skin. Some of the remedies producing overtreatment have been prescribed by physicians which is proof that skin preparations, particularly antipruritics, are marketed with insufficient pharmacologic study. Recently a physician referred a patient for a bullous dermatitis on the arm. When he called he stated that he had prescribed an antihistaminic cream that had made the patient much worse. Past-treatment patch tests showed no reaction to the cream, but an organomercurial produced a bullous reaction. The patient was trying to keep down

the infection at home with a free use of a red antiseptic. "Between treatments" that patients try at home are frequent causes of cutaneous flare ups. Physicians are not told about these treatments. Every patient with an acute dermatitis should be patch tested with all topical remedies as soon as feasible. The tests will protect both physician and patient. The proof that information reaching the public about the skin is misleading is furnished by the fact that the 17 overtreated cases used a total of 83 different skin remedies containing several hundred different chemicals. Dermatologically speaking, treatment of the skin is still tied to the era in medicine when oral potions were swallowed, hit or miss.

Distribution of Cost Liability

Ordinarily, it is thought that skin patients are not people who frequent the hospitals. As of today, they are often bed patients. The housewife with her hands a weeping dermatitis is helpless. An explosive, generalized dermatitis incapacitates the individual. Seven of the 17 overtreated cases experienced this complication from remedies alleged to heal and relieve itching. If the buttocks is the site of a pustular dermatitis, the person cannot sit down. A severe pedal dermatitis places the patient in bed or on crutches. It is not unusual for a therapeutic dermatitis to close the eyelids. Seven patients required hospitalization. They did not go to collect insurance benefits; they went because an organ of their body had been stricken by too much treatment to a point where it could no longer carry on its vital functions.

The total cost for the seven hospital cases was well over \$2,000. The distribution of this liability is shown in Table 1.

Table 1—PER CENT LIABILITY DISTRIBUTION OF OVERTREATMENT DERMATITIS

	Personal Liability	Insurance Liability
Hospital Cost -----	21	79
Medical Fees -----	70	30
Wages Lost -----	47	53

It is apparent that insurance companies pay a good portion of the cost of overtreatment. In Table 2 is shown the per cent distribution of the total overtreatment cost for the seven hospital cases. Medical fees are a minor item in the cost of overtreatment dermatitis; notwithstanding the

fact that we shoulder all the responsibility and work to restore these patients to health.

Table 2—PER CENT COST DISTRIBUTION OF OVERTREATMENT DERMATITIS

Hospital Cost	Wages Lost	Medical Fees
40	45	15

These tables should alert physicians to the importance of sequela from injudicious therapy of the skin. We should condemn lay-treatments of the skin because, unknowingly, we assume responsibility for it when the patients finally come under our care.

Prevention of Overtreatment by Patient Education

Seldom a week passes that an old patient does not telephone the following queries: "I burned the back of my hand on the stove. I put some cornstarch on it. Was that alright?" "We were on an outing several days ago and this morning my little boy has a rash on his leg. I bathed it in oatmeal water and applied some cornstarch. Was that all right?" These experiences are adequate evidence that people are clamoring for safe methods of caring for their minor skin troubles. Patient education is a form of public relations in dermatology that prevents dermatitis, needless suffering and catastrophic drains on the family budget. The following report of a case is typical of this program:

Case C. H., a white housewife aged 55, was seen for the first time in May, 1951. She was susceptible to rhus and had noticed for a number of years that after working in the garden, especially when the weather was hot and humid, little blisters would appear on the sides and backs of her fingers. The present attack appeared on Sunday. Monday was wash day. Unmindful of the lesions, her hands were placed in detergent suds with bleach added. The wash tubs were cleaned out with a scouring powder. That afternoon her hands felt irritated. The little blisters had become red and a few oozed. Some itching was present. She recalled that two years ago she had used a salve for itching that was said to be wonderful. It was found in the medicine chest with the label stained and disfigured. A liberal amount was squeezed out and thoroughly rubbed in. Supper dishes were done in the evening, and later she decided to shampoo her

hair and take a bath. After these duties were finished, her hands were fire-red and itched severely. More of the same salve was rubbed in. During the night she was up and down. To quote, "My hands were driving me crazy. They itched so I thought I would tear them off." In the early morning a soda bath was tried. Lysol was added to prevent infection and kill any stray fungi. A medicated soap was lathered on, and after rinsing and drying, her daughter applied a healing balm.

Early Tuesday morning she was sitting in the office. The odor of Lysol filled the room, mingled with that of camphor and menthol. The hands and forearms were covered with large turkish towels. The right hand was swollen twice its normal size. Bullae were breaking; the contents staining the towels. With her left hand she pointed to her face and legs, "Look, I am breaking out all over." At this moment she would have been a shocking lesson to anyone interested in the pharmacology of cutaneous medications. Caution would circumvent their enthusiasm. The husband and daughter helped her out on her way to the hospital. She had a private room in the hospital for 5 days, required 8 hospital visits and 12 follow up office visits. Post-treatment patch test reactions to the remedies are shown in Figure 1.

During the follow up visits she was given instructions on the judicious use of soap, cosmetics, and so on. After she was well, special warnings were given on the importance of keeping all these agents away from minor skin injuries. She was told that the skin has a remarkable alarm mechanism to warn of danger. Itching, most commonly, warns of a chemical injury. Ignoring this warning is like running a red light. Trouble may be close at hand. Any eruption was to be covered with gauze; and if it was not better in 24 hours, she should visit the office.

Nine months later she was seen. The right hand was covered with a white cotton glove. She related this story. The night before, her grandson complained of his ankle hurting. She rubbed it with Baume Ben-Gay. An hour or so later her hand started to itch and burn. She bathed her hand in some oatmeal water, dusted on some cornstarch and covered it with a cotton glove. She knew it was the Baume Ben-Gay that had produced the symptoms.

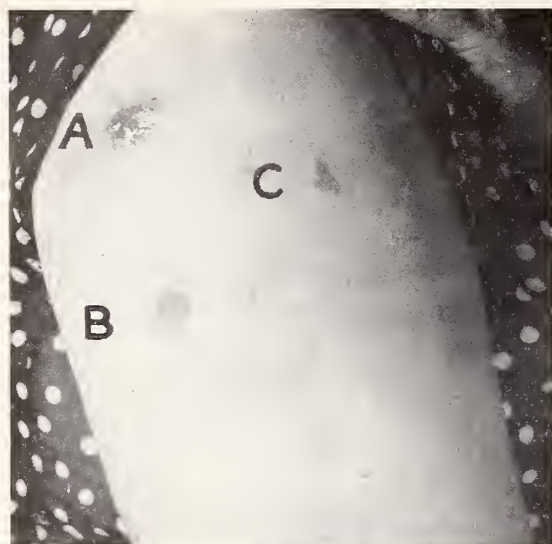


Figure 1. Post-treatment patch test reactions to Topaminic. A; Cuticura Soap, 5% solution; B; Blue White, 5% solution; C. Topaminic contains methapyrilene hydrochloride, calamine, benzocaine and hexylated metaeresol. It is alleged to be soothing, protective and good for itching, sunburn, rhus dermatitis, pruritus, bites and other superficial skin irritations. These pharmacologic and therapeutic actions are not exonerated by the bullous patch test reaction to this remedy.

Only the right hand itched, and this was the one that had applied the analgesic. Teaching her to recognize dermatologic symptoms and heed their warning can be translated into the data shown in Table 3. Instead of trying to relieve them by something in the medicine chest, she sought their meaning and readily discovered their cause. The expense before education was over \$200.

Table 3—COST DISTRIBUTION OF OVERTREATMENT DERMATITIS IN CASE C.H.

<i>Before Education</i>	<i>After Education</i>
Hospital Cost -----64% (Ins. Liab. 80%) (Pers. Liab. 20%)	Hospital Cost ----- 0
Medical Fees* -----36%	Medical Fees ----- 2%
Hospital Visits ---- 8	Hospital Visits ---- 0
Office Visits -----12	Office Visits ----- 1

* Combined cost of hospital and office visits.

Comments

Unless dermatologic patients with contact dermatitis are patch tested with the topical remedies they have used, the etiology of local or generalized exacerbations of initial cutaneous lesions will be missed in approximately 27 per cent of

cases. This diagnostic procedure protects both patient and physician. Self-diagnosis and lay-treatment of skin diseases is a deceptive and costly pasttime. It increases hospital costs, burdens insurance carriers, and strains the family budget. Medical fees are a minor item compared to the total cost. This fact does not prevent the agitators from placing the high cost of medical care on our doorstep.

Teaching patients the need to search out the cause of itching, that dermatologic symptoms most commonly warn of injury to the skin, is a program that protects the health of patients and increases the stature of dermatology. Daubing cutaneous symptoms, masking their warning calls with antipruritic chemicals is a frustrating endeavor, in spite of the fact that these agents are intensively promoted, reprinted and sampled to every physician. Professional colleagues render their patients an injustice, delay the diagnosis, jeopardize their health when they make snap-diagnoses of skin complaints and dismiss them with the remark, "Try this." The patient believes that his surgeon or internist knows all about the skin. If busy housewives can learn to interpret dermatologic symptoms and spare themselves complications, it would seem that others could do the same. Individuals, organizations and institutions that cry about the shortage of physicians will see in Table 3 that professional skills will be more available by the exercise of greater vigilance from within our ranks.

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THE CAROTID SINUS REFLEX:*

II. Use of the Normal Reflex in Bedside Diagnosis Treatment

DAN L. URSCHER, M.D.

Mentone

THE so-called carotid sinus reflex is one of a number of neurovascular reflexes which act to maintain normal blood pressure and cardiac rate in humans. It is of special interest to clinicians because of the clinical syndrome resulting from pathologic-hyperactivity of the reflex. The "Carotid Sinus Syndrome", or "Cardio-inhibitory Carotid Sinus Syndrome" was first comprehensively described by Weiss and Baker¹ in 1933, although it had been recognized in part over a century before. Hering² had, in 1927, first described accurately and in detail the nerve areas and neurovascular mechanisms involved in the reflex, normal and abnormal.

It is not our purpose at this time to discuss the carotid sinus syndrome, which has been adequately described in detail in the first paper of this series³. Instead, the author wishes to point out the ways in which the normal reflex may be used diagnostically and therapeutically in clinical practice. Some of these uses, especially in regard to the tachycardias, are well known, whereas others may not be so generally recognized.

Technique for Eliciting the Reflex

The technique of eliciting the reflex has been described and illustrated previously³ and need only be briefly repeated here. The carotid sinus is a bulbous dilatation at or near the bifurcation of the common carotid artery. In most patients it can be located without difficulty just below the angle of the jaw, with the head tipped upward and to the opposite side. It can usually be located best by palpating the carotid lower in the neck, then carefully following the artery upward to the bifurcation. This is an important matter, as the sinus should be clearly distinguished before pressure is applied. Even in experienced hands it is sometimes difficult to be sure that the pressure is being applied to the sinus area, and

not to an adjacent segment of the carotid. After the sinus is accurately defined it is pressed firmly against the adjacent transverse vertebral process, the pressure being maintained no longer than 30 seconds in any one test, except as will be mentioned later. Gentle massage of the sinus is often of aid, and pressure should be applied with two or even three fingers to assure even distribution. Unless there is present the contraindication of age or advanced arteriosclerosis, the test may be freely repeated without danger. Bilateral tests should never be performed simultaneously, one side being tested at a time. The right carotid sinus has generally been more reactive in the author's experience, though there are many exceptions. However, in almost all cases, one side is more sensitive than the other.

Transient or permanent cerebro-vascular damage has been occasionally reported as occurring following carotid sinus pressure. In almost all instances these accidents occurred in elderly arteriosclerotic individuals, and because of this the test in such patients should be performed only when absolutely necessary, and then with special precautions regarding duration of pressure, careful delineation of the carotid sinus, needless repetition of the test, et cetera.

The test can usually be carried out with the patient in the recumbent position, as the cardio-inhibitory effect (with which we are principally concerned in this paper) can be elicited as readily in the recumbent as in the erect position. The vasodepressor (or hypotensive) effect is best demonstrated with the patient sitting or standing.

Finally, it is to be emphasized again that in most of this paper we are dealing with the normal reflex mechanism and not with the abnormal carotid sinus syndrome. Pressure on the carotid sinus sends impulses by way of the carotid sinus nerve, a branch of the glossopharyngeal, to the vasodepressor and vagus (cardio-inhibitory) centers in the brain. Efferent impulses pass out through the sympathetics to the vascular system,

*This is the second of a series of three articles by Doctor Urschel.

producing peripheral vasodilatation and lowering of the systemic blood pressure, and through the vagus to the heart, producing cardiac slowing of varying degree by inhibiting the SA node or by delaying conduction through the AV node. These two effects (lowering of the blood pressure and slowing the cardiac rate) can be demonstrated to some degree in almost all normal individuals, and are the basis for the various therapeutic and diagnostic procedures described in this paper.

Use in the Arrhythmias

This is the most common and best defined use of the carotid sinus reflex, and the effects in the various rate and rhythm abnormalities have been summarized in Tables I and II.

The principal value here lies in diagnosis, as only in paroxysmal auricular tachycardia is there predictable therapeutic response to carotid sinus pressure. (Stellar⁴ has recently reported two cases of nodal paroxysmal tachycardia in which

TABLE I. THE EFFECT OF CAROTID SINUS PRESSURE UPON THE ARRHYTHMIAS WITH RAPID REGULAR RATE.

<i>Type of Arrhythmia</i>	<i>Effect of Carotid Sinus Pressure</i>
Paroxysmal Auricular Tachycardia	Two possibilities—either an abrupt cessation of the tachycardia with brief asystole and resumption of normal rhythm; or no response at all.
Paroxysmal Ventricular Tachycardia	No response.
Auricular Flutter	Several possibilities, one of which is diagnostic—an abrupt reduction, usually by half, in the apical rate, with resumption of the previous rate when pressure is released. Another characteristic response is brief total ventricular asystole, with resumption of rapid rhythm. (The cardiogram during this interval will show the typical flutter waves.) There may be no response. This is more common than the above diagnostic changes, unfortunately.
Sinus Tachycardia	Moderate slowing during period of pressure, with gradual return to rate approximating previous one.

TABLE II. THE EFFECT OF CAROTID SINUS PRESSURE UPON THE ARRHYTHMIAS WITH RAPID IRREGULAR RATE.

<i>Type of Arrhythmia</i>	<i>Effect of Carotid Sinus Pressure</i>
Auricular Fibrillation	Non-diagnostic and inconstant slowing of the apical rate.
Ventricular Fibrillation	No response.
Sinus Tachycardia with extrasystoles	The extrasystoles are not affected, but the basic ventricular rate may be reduced sufficiently to enable the observer to distinguish the irregularity from auricular fibrillation with which it may be confused.

normal rhythm was restored by this method.) We are here dealing with the cardio-inhibitory, or vagotonic, effect, and it must also be emphasized that the carotid sinus reflex is not the sole means by which increased vagus tone may be elicited. Eyeball pressure, breath-holding, induced vomiting, or the Valsalva maneuver may all have a similar effect, and one or more of these may be more effective than carotid sinus pressure in certain individuals, so that all should be tried in indicated circumstances. In younger individuals with paroxysmal auricular tachycardia or flutter there appears no contraindication to pressure of more than 30 seconds duration if it appears that prolonged stimulation will achieve the desired result. Careful auscultation during the test may demonstrate brief periods of response which can be made permanent (in paroxysmal auricular tachycardia) by more prolonged pressure.

In sinus tachycardia the mechanism producing cardiac slowing is inhibition of the SA node, but in the other arrhythmias it is the production of varying degrees of AV block. A thorough understanding of these physiologic responses will enable the physician to make an accurate bedside diagnosis in a high percentage of patients with tachycardia.

In Angina

Levine and Harvey⁵ have reported relief of acute anginal pain in almost every patient in whom carotid sinus pressure produced cardiac slowing. This response occurred in a few seconds, being more rapid than with nitroglycerine.

The only failures were in 5 patients (of 50 observed) who had no reduction in cardiac rate. Of the remaining 45, 70 per cent had total relief from distress, 30 per cent partial relief. The test was also used in 60 patients with other causes for pain, and only 7 of these reported any change in distress. This control group included many different causes of pain, including several patients with acute myocardial infarction.

This maneuver has proven useful in a number of cases of angina in the author's experience and in one case the patient has been taught to apply carotid sinus pressure to relieve his attacks of pain.

In Auscultation of the Heart

The accurate timing and identification of cardiac murmurs is often difficult or impossible in the presence of a rapid cardiac rate. In such patients temporary slowing by the use of carotid sinus stimulation may clarify the problem. This may be true even in tachycardia of only moderate degree, and the author uses the maneuver repeatedly in auscultation of the heart. The amount of sinus pressure necessary is often minimal, and of no danger to the patient. Also, as was noted in the discussion of the arrhythmias, most of these patients are young adults or children, in whom the contraindications to sinus pressure are of lesser importance. This is a valuable aid often neglected in examination of the heart.

In the Differential Diagnosis of Syncope, Unconsciousness, or Convulsive States

Here we are dealing with the carotid sinus syndrome, or pathologic carotid sinus reflex, which has been repeatedly described and is generally well known³. We need say little about it at this time except to reemphasize the point that the carotid sinus syndrome should always be considered in the differential diagnosis of patients presenting these complaints. Too many "incurable epileptics" have been cured by therapy for their carotid sinus syndrome to allow us to neglect this diagnostic aid. This is especially true in elderly, arteriosclerotic, or hypertensive patients, those in whom the carotid sinus syndrome is most common. One point is particularly worthy of emphasis—carotid sinus pressure

must not only produce bradycardia or hypotension, but it must reproduce the patient's symptom complex in order to make the diagnosis of carotid sinus syndrome. As we have repeatedly emphasized, bradycardia and hypotension are normal responses in many patients and do not alone constitute the carotid sinus syndrome.

In Differential Diagnosis of Meniere's Disease

The carotid sinus syndrome may produce symptoms similar to those resulting from organic disease of the vestibular apparatus. As in the conditions listed in the preceding paragraph, awareness of the possibility of carotid sinus disease is of great importance.

In Differential Diagnosis of Organic Cardiac Disease

The carotid sinus syndrome frequently leads to a diagnosis of organic heart disease, occurring as it does in patients who are in the age group where arteriosclerotic heart disease is common. The differential diagnosis may be difficult, as in the Stokes-Adams seizures⁶, because of the co-existence of coronary sclerosis. Palpitation and vague chest distress often follow the attacks of carotid sinus syndrome, and apprehension is almost always prominent. Correct diagnosis is vital here because of the entirely different prognostic implications of the carotid sinus syndrome and of organic cardiac disease. Also, digitalis sensitizes the reflex, and if incorrectly given, may aggravate the patient's difficulty.

In the Diagnosis of Arteriosclerosis

Goodman and Wassermann⁷ have suggested that the pure vasodepressor reaction, without associated bradycardia (or hypotension lasting more than 3 minutes after the bradycardia has ended), is diagnostic of atherosclerosis of the "proximal arteries", i. e., the aorta, innominate, subclavian, and carotids. They feel that the atheromatous deposits in the aorta disturb the chemoreceptors which act as a pressor mechanism in opposing the carotid sinus depressor effect. It has been well known for years that older arteriosclerotic individuals are much more prone to a pathologic hyper-reactivity of the carotid sinus mechanism, but it appears doubtful that the test can be used to diagnose the presence

of "proximal" atherosclerosis, as Goodman and Wassermann suggest. Adequate control studies are lacking in their presentation, and other factors are known to affect the sensitivity of the carotid sinus mechanism.

Carotid Sinus Sensitivity in Anesthesia

Rovenstine and Cullen have pointed out the dangers involved in anesthesia in patients with a hyperactive carotid sinus mechanism. They have pointed out the sensitizing effects of various pre-operative medications, such as digitalis, certain barbiturates, and Avertin. Cyclopropane was their anesthetic of choice, with morphine as the only pre-operative medication. Atropine eliminates the vagal (cardio-inhibitory) response and may be used in patients who have this type of reaction only. Ether, Vinethene, and chloroform sensitize the reflex in light anesthesia, depress it as the narcosis deepens.

Rovenstine and Cullen also point out the possibility of the anesthetist inadvertently stimulating the reflex mechanism by pressure beneath the angles of the jaw. This appears to be a real danger, especially in early induction of anesthesia when the patient may be struggling and the level of the anesthetic is such as to sensitize the reflex.

Summary and Conclusions

1. The carotid sinus reflex has been reviewed, with emphasis on the technique for eliciting the mechanism, and on the diagnostic and therapeutic uses of the test.

2. In *diagnosis* it is important in the arrhythmias with rapid cardiac rate, especially those with regular rhythm; in the differential diagnosis of conditions causing syncope, unconsciousness, and convulsions; in Meniere's syndrome; in certain types of organic heart disease such as total AV block with Stokes-Adams seizures; as

an aid to auscultation when reducing the cardiac rate is important; to some extent in the differential diagnosis of chest pain; and possibly in the diagnosis of aortic arteriosclerosis.

3. In *therapy* the carotid sinus reflex is principally useful in paroxysmal auricular tachycardia, where proper pressure often restores normal rhythm. Nodal tachycardia has been likewise affected, but the other types of rapid regular or irregular arrhythmias are not helped. In acute paroxysms of angina the reflex is of value in relieving distress, if the cardiac rate can be slowed.

4. The importance of the reflex in anesthesia has been reviewed, with precautions to be followed in patients with a hyperactive reflex who require surgery.

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Clinical Observations On Pancreatic Malignancies

THEODORE S. MALINOWSKI*

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CLINICAL experiences with carcinoma of the pancreas at this Medical Center are comparable to those reported by others in that the diagnostic difficulties along with the high morbidity and mortality rates add to the discouraging and dark picture. Despite all this, the overall picture appears to be a little brighter, in light of the intensive studies and reports on carcinoma of the pancreas that are appearing in the literature. Interest in pancreatic malignancies has increased and more cases are being detected earlier because many physicians are not forgetting that the patient also has a pancreas. It only has been during the last few years that we have begun to study intensively the problem of pancreatic malignancies and to date our studies are predominantly clinical, with interest in the early diagnosis by means of pancreatic function studies. Pertinent observations, as well as studies conducted at this hospital on carcinoma of the pancreas, form the basis of this report.

The incidence of carcinoma of the pancreas, in regard to all cancers of the abdomen is 6 per cent; the over-all mortality rate, even after surgery, is reported as approximately 85 per cent¹. This high mortality rate appears to be directly related to the delay on the patient's part in seeking medical attention early in the course of the illness and to delay in establishing the diagnosis. Our observations conclusively indicate that patients who were seen for the first time at this hospital after being jaundiced for two months or longer had a mortality rate of 100 per cent, and lived only for four to six months. Those who had been jaundiced less than one month had a better prognosis.

The need for early diagnosis is urgent and undeniable if we are to improve the mortality rate in this disease. The dilemma that frequently confronts the clinician upon seeing such a patient who has been jaundiced for several weeks to a month, is to differentiate between the so-called "medical jaundice" due to liver cell dam-

age and "surgical jaundice" due to interference to bile flow on the basis of extra-hepatic obstruction. In the latter, with long standing obstructive jaundice on the basis of a malignancy, the liver cells are invariably damaged, and biliary hepatitis or cirrhosis is evident. This perplexing problem frequently confronted us, inasmuch as a majority of our patients were jaundiced for several weeks prior to admission to this hospital. It is hoped that some worthwhile facts emerge from this study that may be of value in the early diagnosis of these malignancies.

General Considerations. This report is on 28 cases of carcinoma of the head of the pancreas. Four cases of carcinoma of the body were seen, but were excluded because of incomplete studies. Three cases of carcinoma of the tail are reported; two of which were neither diagnosed nor suspected antemortem, and the other finally became obvious to us terminally. Also included in this report are three cases of carcinoma of the ampulla of Vater and three cases of carcinoma of the gallbladder because of the similar clinical features that they presented. The diagnosis was established in all cases either by surgical exploration or autopsy.

Table 1 presents the general data on the various malignancies of the pancreas and biliary tract. It is of interest to note that males predominated over females in all the malignancies except those of the gallbladder. Seventy-five per cent of the patients with carcinoma of the head were 60 years of age or older, while all cases of carcinoma of the tail were confined to relatively young males. The incidence of carcinoma of the gallbladder in older age groups concurs with the reports of others². The mortality rate for carcinoma of the head is inconclusive, for the status of five patients is not known and only three are reported alive. The probable mortality rate is 71 per cent. The mortality rate of carcinoma of the tail of the pancreas is invariably 100 per cent, namely because they are not detected nor suspected early until massive metas-

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TABLE 1
GENERAL DATA ON MALIGNANCIES OF THE
PANCREAS AND BILIARY TRACT

Location	Number of Cases	Sex		Age Groups				Mortality Rate
		M	F	40-50	50-60	60-70	70-80	
Head of Pancreas	28	19	9	3	4	14	7	75%
Tail of Pancreas	3	3	0	3	—	—	—	100%
Ampulla of Vater	3	3	0	1	1	1	—	33%
Gall Bladder	3	1	2	—	1	2	—	66%

tases have occurred. Carcinoma of the tail notoriously extends much more massively, and metastasizes more widely than that of the head or body, and still rarely is it diagnosed ante-mortem. The mortality rate of carcinoma of the gallbladder was 66 per cent. Russell³ reported that surgery for this disease is unsatisfactory and there were no five year cures in his series of 29 cases. One of our cases is still alive inasmuch as the malignancy was discovered accidentally while undergoing cholecystectomy for cholelithiasis and the tumor was still localized in the fundus of the gallbladder.

Etiology. The question arose if these patients with malignancies of the pancreas and biliary tract had characteristic histories, habits or associated diseases that were of etiological significance (Table 2). It was of interest to find that 40 per cent of the cases of carcinoma of the head had previous biliary tract disease; however, on the other hand biliary tract disease is present in 20 to 25 per cent of the adult population, and the incidence increases with age². Thus, too much significance cannot be attached to the high incidence of associated biliary tract disease in these cases. One significant finding was that

TABLE 2
POSSIBLE ETIOLOGICAL FACTORS

Location of Carcinoma	Previous Biliary Tract Disease	Alcoholism	Diabetes	Dietary Habits
Head	12 (43%)	6 (20%)	3 (11%)	?
Tail	0	1	0	?
Ampulla	0	1	0	?
Gall Bladder	3	0	0	?

all three cases of carcinoma of the gallbladder had cholelithiasis. Various reports reveal an associated cholelithiasis with carcinoma of the gallbladder to be from 75 to 100 per cent^{3,4}. Our small series supports the latter incidence. It has been frequently observed that the presence of gallstones must be related to the origin of carcinoma of the gallbladder and experimental studies have shown that derivatives of cholic acid are among the most powerful of carcinogens².

The role of diabetes or insufficiency of insulin *per se* appears to be of no etiological significance. One patient had mild diabetes for 10 years, but of diagnostic significance is the fact that two patients developed diabetes three and six months respectively before the onset of their jaundice. The role of alcoholism was studied inasmuch as alcohol stimulates the pancreas to secrete a highly concentrated pancreatic juice. An incidence of 20 per cent appears to be of etiological significance. The questionable role of food, food products and dietary habits still remains unanswered and should be further investigated.

Clinical Features. Only the significant clinical features are presented in Table 3. The

TABLE 3
SIGNIFICANT CLINICAL FEATURES OF
PANCREATIC AND BILIARY TRACT
MALIGNANCIES

Location	Jaundice	Pain	Palpable Mass	Hepatomegaly	Metastases to Liver
Head	24 (93%)	21 (82%)	13 (46%)	20 (71%)	8 (40%)
Tail	1	3	0	2	3
Ampulla	3	2	0	3	0
Gall Bladder	3	2	1	3	1

striking feature in these cases was the association of pain with the jaundice. This is in agreement with the reports of others^{1,5,7}. The old concept of painless jaundice being diagnostic of malignancy of the head of the pancreas must be discarded for not only is it erroneous, but also misleading. In our series of 28 cases of carcinoma of the head, 82 per cent had pain and 5 cases had painless jaundice. Two cases had pain without jaundice. In analyzing the duration of jaundice prior to admission to this hospital, it was found that the majority of the cases of car-

cinoma of the head were jaundiced for four weeks or longer, while those of the ampulla less than four weeks.

A palpable firm mass in the epigastrium was found in 46 per cent of the cases of carcinoma of the head, and less than one-third of the cases had a palpable gallbladder to physical examination; however, on surgical exploration or autopsy, approximately 65 per cent of the cases had a distended gallbladder.

The pain, in practically all cases of carcinoma of the head, preceded the jaundice, and in 90 per cent of the cases the pain was described as boring in character and localized high in the abdomen, usually in the right epigastrium. Approximately two-thirds of the patients described the pain as dull, constant and boring, while one-third described it as sharp, severe and boring. In the cases of malignancy of the tail, one had pain in the left xyphoid and lower thoracic regions; one had persistent, dull gnawing epigastric pain, and the other had generalized abdominal pain.

The presence of hepatomegaly in 71 per cent of the cases with malignancy of the head of the pancreas was of significance, as well as frequently confusing to the clinical picture. This clinical finding was also characteristic of the other malignancies. The question arose if the hepatomegaly could have resulted from metastases to the liver. Pathological findings revealed metastases to the liver in 40 per cent of the cases with carcinoma of the head; 100 per cent in those of the tail, and in one case of carcinoma of the gallbladder and this by direct extension into the liver.

Laboratory Findings. The significant as well as useful laboratory tests that frequently were of value in establishing the diagnosis in these cases are presented in Table 4. Malignancies of the tail have been excluded since the tests were of no diagnostic value, nor suggestive of pancreatic malignancy. In 24 cases of carcinoma of the head with jaundice it was of interest to note that the degree of jaundice was complete in 46 per cent and incomplete in 54 per cent. Urinary urobilinogen was significantly reduced to absent in the former group, while in the latter group, the urinary urobilinogen frequently was within normal values; however, it was found to be elevated in three cases and highly suggestive of "medical jaundice". Alkaline phosphatase

TABLE 4
LABORATORY FINDINGS IN CARCINOMA OF THE PANCREAS AND BILIARY TRACT

Finding		Head	Tail	Ampulla	Gall Bladder
Anemia		60%	1	0	1
Degree of Jaundice	Complete	46%	0	2	2
	Incomplete	54%	1	1	1
Urinary Urobilin	Reduced or absent	62%	—	1	—
Elevated Alkaline Phosphatase		92%	1	0	2
Abnormal Liver Profile		37%	1	0	1
Serum Proteins		32%	0	0	1
Hypoprothrombinemia		53%	0	1	1
Occult blood in stools		43%	0	1	1

and blood cholesterol levels were invariably found to be elevated in malignancy of the head.

In view of the diagnostic difficulties encountered because of the jaundice, all cases were thoroughly studied for evidence of liver cell damage. The tests utilized were cephalin-cholesterol flocculation, thymol turbidity and bromsulphalein retention. These tests, in combination of two or three were indicative of liver cell damage in 37 per cent of the cases. If we include the cases with hypoproteinemia and an abnormal A/G ratio, then 69 per cent of the cases studied showed evidence of liver cell damage which would tend to mislead the clinician into thinking in terms of medical jaundice. However, when one considers that these patients had longstanding jaundice, the biliary hepatitis or cirrhosis that results is apparent. The last case seen had this secondary diagnosis confirmed by a needle biopsy of the liver.

Prothrombin time determinations in essence were non-contributory, for abnormalities in this test, as is well known, depend upon the absence of bile from the intestine or liver cell damage, both of which were present in many cases.

One simple and informative test in these malignancies is for the presence of blood in the feces. The test for occult blood was positive in 43 per cent of the cases with carcinoma of the head, while only one patient with carcinoma of the ampulla had his stool tested for blood, and the result was positive. The hypoprothrom-

binemia apparently is not the basis for the positive test for occult blood, for only in two cases was it at the critical level (13 and 21 per cent of normal), while the remainder had prothrombin time levels above the critical level (40 to 60 per cent of normal). It appears that the basis for the presence of blood in the feces is bleeding or oozing of the malignant lesion itself or probably also destructive changes of adjacent tissues and blood vessels.

Recently studies were undertaken to determine if any deviations from normal pancreatic function existed in cases of pancreatic malignancies, and if so, could such deviations be of diagnostic value. Studies on pancreatic function have been intensively utilized for several years at this hospital in pancreatic diseases other than malignant, and have proven to be quite helpful.

The problem of differentiating between obstructive jaundice resulting from carcinoma and that resulting from common duct stone is frequently difficult. Our approach to this problem namely was along the following lines: In malignancies of the pancreas or the ampulla of Vater, we reasoned that some degree of pancreatic duct or ductal obstruction usually existed, and following stimulation of the pancreas, the impairment of flow of enzymes would be reflected by a significant rise in serial serum amylase levels. Along the same line, we reasoned that there would be no rise in serum amylase values in obstructive jaundice due to non-malignant lesions, such as common duct stones. Our investigative studies in a small number of cases have borne this out, for the prostigmine-amylase test⁶ was negative in 10 cases of obstructive jaundice due to common duct calculi, while it was positive in four cases out of five in carcinoma of the head, and in two cases of carcinoma of the ampulla of Vater.

Random serum amylase determinations have been reported to be elevated in approximately one-third of the cases of carcinoma of the head of the pancreas⁷. However, one must be cognizant of the fact that elevated values are present early in the course of the disease, usually during the first three or four weeks, and then fall to normal levels as the malignancy progresses causing atrophy of acinar cells. Finally, with extensive atrophy of acinar cells, the serum amylase levels drop to low values (4060 mgs. per cent); this was observed in three of our cases.

TABLE 5
PANCREATIC FUNCTION STUDIES IN A
SMALL NUMBER OF CASES OF MALIG-
NANCIES OF THE PANCREAS
AND BILIARY TRACT

	Head	Tail	Ampulla	Gall Bladder
<i>Serum Amylase:</i>				
Elevated -----	4	0	2	0
Normal -----	2	2	—	3
Decreased -----	2	1	—	—
<i>Prostigmine—</i>				
<i>Amylase Test:</i>				
Positive -----	4	0	2	0
Negative -----	1	1	—	2
<i>Hyperglycemia:</i>				
Present -----	10	1	1	0
Absent -----	4	2	2	3
<i>Glucose Tolerance:</i>				
Decreased -----	6	1	—	0
Normal -----	2	—	—	1
<i>Steatorrhea:</i>				
	4	1	0	—

Another early disturbance of pancreatic function that frequently was seen in carcinoma of the pancreas was hyperglycemia and a decreased glucose tolerance. Out of 14 cases of carcinoma of the head, in which blood sugar determinations were performed, ten had significantly elevated blood sugars. An oral glucose tolerance test was performed in only eight cases with carcinoma of the head; the finding of a decreased tolerance to glucose in six cases was of significance. Evidence of hyperglycemia and hyperamylasemia or a positive prostigmine test in a patient with painful jaundice is conclusive evidence of malignant disease of the pancreas.

Roentgenological examinations have been reported to be of limited value in the diagnosis of malignancies of the pancreas. We found that roentgenological studies in carcinoma of the body and tail were of no value. In carcinoma of the head of the pancreas, upper gastrointestinal examination with barium was of diagnostic value in 13 out of 23 cases (55 per cent). In the 13 cases with positive upper gastrointestinal x-ray findings, eight cases revealed pressure deformity of the duodenum and widening or displacement of the duodenal loop; while the remaining five cases revealed pressure deformities of the pyloric antrum.

Discussion. It is extremely difficult to concisely discuss this perplexing problem of early detection of pancreatic malignancies; however, from our studies of this disease, a few observations emerge that appear to be of interest and perhaps of value in cases that are encountered or suspected in the future. More than often, these patients for the first week or two of their illness, while jaundiced, are erroneously diagnosed and treated for cholecystitis or "liver disease". Inasmuch, as we have had more experience with carcinoma of the head of the pancreas, the remainder of this discussion will be limited to this disease.

The frequent association of pain with the jaundice has already been pointed out and requires no further comment. The presence of hepatomegaly with the jaundice in such cases still poses quite a problem in differentiating between surgical or obstructive jaundice and medical or hepatic jaundice. Popper⁸ in his series found that 60 per cent of the cases with surgical jaundice had liver cell damage present. Our series revealed laboratory evidence of liver cell damage in 69 per cent of the cases. The laboratory findings which were of value in establishing the diagnosis of obstructive jaundice were an elevated alkaline phosphatase level, an elevated blood cholesterol, absent or reduced urinary urobilinogen, and a normal A/G ratio. Laboratory findings which were strongly suggestive of malignancy as the cause of the obstructive jaundice were anemia, occult blood in the stools, increasing hyperbilirubinemia, hyperglycemia, hyperamylasemia, and abnormal x-ray findings.

Elevation of the serum amylase during the first four weeks of the disease will be found in 30 to 40 per cent of the cases of carcinoma of head. Our experience with the prostigmine test in pancreatic malignancies, though suggestive of being of diagnostic value, is still inconclusive and must await more extensive application and evaluation. Hyperglycemia is a valuable finding in suspected carcinoma of the pancreas, and it is present in 25 to 50 per cent of the cases¹. True diabetes is said to develop in about 10 per cent of the cases; two of our cases bear this out. Steatorrhea and/or creatinuria was detected in a small number of our cases, but when this evidence of pancreatic insufficiency was apparent, the diagnosis was obvious and the malignancy inoperable.

Roentgenological findings were of diagnostic value in 55 per cent of the cases with carcinoma of the head. Such indirect studies of the pancreas are admittedly of limited value; however, until technics and methods are eventually developed and perfected for direct examination of this elusive organ, these indirect x-ray studies should be included in the diagnostic armamentarium of clinicians confronted with suspected cases of carcinoma of the pancreas.

Conclusions. The crux of the problem in carcinoma of the pancreas is early detection and early surgical intervention in order to improve the current mortality rate, as well as increase the number of "five year cures". Ideally, a simple screening test is needed in which an early characteristic finding would strongly suggest malignancy to the clinician as does achlorhydria in malignant gastric ulcer. Such an approach to the problem of early detection of pancreatic cancer necessitates further intensive studies on the physiology of this endocrine gland—endocrine in that not only does it elaborate insulin into the circulation, but also amylase, lipase, lipotropic factors, and a hyperglycemic factor. Studies of this aspect of the endocrinology of the pancreas may some day lead to more simple and informative tests of pancreatic function, with clinical application to the early diagnosis of pancreatic cancer.

However, for the present, prompt investigation into the type of jaundice, appreciation of the fact that the patient has a pancreas, utilization and critical interpretation of hepatic and pancreatic function studies should increase the number of cases diagnosed early and substantially improve the present surgical results in terms of five year cures.

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STATE AMEF CHAIRMEN TO MEET

American Medical Education Foundation state chairmen will kick off the 1953 fund-raising drive with a meeting Sunday, January 25, at the Sheraton Hotel in Chicago. This second annual meeting will launch officially the medical profession's concerted effort during the coming year to raise voluntary funds to assist the country's medical schools. Keynote speaker will be L. D. McGuire, M.D., AMEF chairman for Nebraska.

Chief value of the meeting will be to exchange experiences and ideas on local fund-raising promotions. Representatives from every state will be on hand for the one-day session.

LAUNCH 5 MILLION DOLLAR MEDICAL EDUCATION CAMPAIGN

The National Fund for Medical Education, with offices in New York, is launching a five million dollar industry-wide solicitation campaign in support of medical education in the United States.

Colby M. Chester, newly-appointed chairman of the fund's Committee of American Industry, will direct a nation-wide organization to mobilize business concerns behind the nation's hard-pressed medical schools. Mr. Chester is honorary chairman of the board of General Foods Corporation.

The National Fund for Medical Education is a lay organization which is working in conjunction with the American Medical Education Foundation, founded by the American Medical Association two years ago. The AMEF's goal for 1953 is included in the five million dollars.

The National Fund's Committee of American Industry, which will spearhead the campaign, will be composed of 100 ranking business leaders from every segment of industry. Their task will be to educate industry as to the critical needs of the medical schools. The committee contemplates solicitation of 25,000 American business concerns during 1953. Mr. Chester plans to appoint a vice-chairman, an advisory council, and division chairmen, who will direct the activities of more than 50 industrial committees. E. J. Ade, New York, has been appointed fund-raising director for the campaign.

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ROBERT M. MOORE

WHEN the Indiana Heart Foundation dedicates the Heart Clinic of the Indianapolis General Hospital to the memory of Dr. Robert M. Moore it will honor an outstanding teacher and beloved physician.

No more fitting tribute could be paid to Bob Moore's skill as a teacher than to have the clinic, to which he gave so liberally of his time, named in his honor.

For many years of his active professional life the weekly meetings of the clinic were graced by Doctor Moore's presence, and as a result the clinic was always filled with a multitude of patients and students.

Although the clinic was held at midday on Saturday—probably the most inconvenient time of the week—it was attended by many students, and usually by several active practitioners who came to learn at the feet of a master. Roll call was not necessary. Students were punctual, and many students from other classes were regular participants.

The clinic experienced its share of obstacles and vicissitudes through the years but survived these difficulties under Dr. Moore's leadership. At one time it was the most popular teaching clinic at the Indianapolis City Hospital. The most frequently heard item of conversation among students of those days on Saturday morning was "Let's be sure and get to Bob Moore's heart clinic."

Teaching came naturally to Doctor Moore. He loved to teach and whether the day's work found him on the ward or with private patients he was always accompanied by undergraduate or graduate students.

He would have been a great teacher even without his academic rank, or without his teaching clinic. However the clinic itself will be remembered by hundreds of physicians as one of the most enjoyable experiences in their medical education. The dedication of the Robert M. Moore Heart Clinic will be joined in the hearts of countless doctors who will not be able to attend the formal ceremonies.

AMERICAN LEGION

RECENTLY the Indiana Department of the American Legion requested the formation of a liaison committee for the consideration of problems common to the Legion and the Indiana State Medical Association.

Ample precedent for this type of cooperative effort is afforded on the national level. The National Headquarters of the Legion has for many years utilized its own National Medical Advisory Board, formed from its membership for the investigation and discussion of medical matters. More recently the liaison committee of the A.M.A. has met with a similar national Legion committee.

Our Association's liaison committee has been formed and has met with its Legion counterpart together with representatives of the Indiana Dental Association and the Indiana Hospital Association. This was the first such meeting on a state level. It was also attended by representatives of the Legion National Headquarters,

the A.M.A., the American Dental Association and the American Hospital Association.

At the present time the actual business which was transacted is of lesser importance than the fact of the meeting itself. It is a well known fact that any and all problems are better solved when the solution is achieved on a plane nearest the grass roots.

Some of the biggest arguments are based on misunderstanding on one or both sides. The American Legion and the medical profession have been on the same side of several big issues. There is no reason why differences cannot be composed by cooperative effort.

Discussion of these same problems at the December meeting of the American Medical Association in Denver resulted in the adoption of a resolution in which the House of Delegates suggested that all states follow the Indiana plan in forming a liaison committee from interested groups to discuss and, it is hoped, eventually solve their common problems.

ANSWER THE CALL

EVERY month in the year thousands of people in need or distress reach out to the Red Cross for the help they must have, help that comes from the generous efforts and support of housewives, businessmen, industrial workers, school children, professional workers — your nextdoor neighbors—and countless others who serve their fellow man through the Red Cross.

In a time of tension and cynicism it is well to be reminded of the inherent goodness of people, to call attention to their constant voluntary efforts to make life a little better for the men and women in the armed forces, for hospitalized veterans, for disaster sufferers, and for those in need in other lands.

Although the heart and hands of the Red Cross are provided by hundreds of thousands of volunteers, money is also needed to collect blood; to provide financial assistance for servicemen, veterans, and their dependents; to furnish emergency aid and rehabilitation to disaster victims—services that can be provided only through the voluntary financial support of millions of Americans.

Every March Red Cross volunteers turn to their neighbors and ask help in answering the call of those in need. Let us respond generously to this appeal so that we can answer the call of humanity through our Red Cross.

Editorial Notes

The National Association of Retail Druggists recently requested the A.M.A. to cooperate in ending the continued practice of a great many physicians to require and compel their patients to take their prescriptions to certain designated pharmacies. This request seems a trifle unusual, since many pharmacies furnish physicians with prescription blanks which carry the pharmacy's name and address, apparently for this very purpose. Some states have a doctor-druggist agreement to discourage the furnishing and use of blanks imprinted with the druggist's name. It is felt that the use of a non-advertising blank makes for a little more dignity on both sides.

Ellettsville, Indiana, and the story of how its citizens obtained a doctor are the subject of the lead article in a recent issue of *Progress in Health Services*. "Progress" is a pamphlet published by the Health Information Foundation of New York. It has a national circulation. The "Ellettsville Story" is interesting in that it outlines the plan by which public spirited citizens encouraged and made welcome a general practitioner for a town which otherwise might not have attracted a doctor.

The Life Insurance Medical Research Fund which is supported by the majority of life insurance companies of United States and Canada, six of whom are Indiana companies, has just published its seventh annual report. The fund contributed almost \$800,000 in 1952 to medical schools and research workers. The seven-year total is close to five million dollars.

Each of the insurance companies contributes to the fund in proportion to its volume of business. Grants are made for research on diseases of the heart and arteries on the recommendations of an advisory council whose members are chosen from the faculties of medical schools.

At the present 86 research programs are being supported financially, as well as 35 research fellowships. Arteriosclerosis, hypertension and rheumatic heart disease are the principal research subjects.

The National Safety Council recently conferred an Award of Honor on the U. S. Naval Ordnance Plant, Indianapolis, for the operation of its facilities for a total of 4,094,099 man-hours from March 20, 1951, to January 5, 1952, without a disabling injury.



Medical Panorama by the ASSOCIATE EDITOR

SMOG,—AND THE LIKE

We hold these rights to be inalienable: the rights to life, liberty and the pursuit of happiness. This being granted, it follows that as air-breathing animals our right to an atmosphere of sufficient purity is also inalienable, otherwise our right to life is threatened. In this age of vast pollution of the air by industrial and combusive by-products, man, through lack of any natural power of aeroscepsis except detection of odors, is at a disadvantage in protecting himself against many of these noxious agents. The extent of this as a public health problem is discussed by Robert B. Marin, M.D., in *The Journal of the Medical Society of New Jersey*, November, 1952, some extracts from which follow:

While John Q. Public has long accepted smoky air as part of urban living, rebellion is in the offing. Poor visibility, grime and smell are no longer welcomed as signs of economic wealth and well being. Disasters such as those in the Meuse Valley of Belgium in 1930, and Donora, Pennsylvania, in 1948, have focused public attention on air pollution and the danger which lurks in the haze. Mills,¹ reports that pollution of city atmosphere constitutes a health problem of the first magnitude and completely over-shadows such factors as inadequate housing, over-crowding, and poor nutrition. Health-giving sunshine is lost, fogs intensified, buildings soot-streaked, clothing and furniture soiled, and lungs blackened. The attitude and the efficiency of the individual are impaired. The amount of ill health among people subject to air pollution for prolonged periods is significantly greater than the amount of ill health among people living in areas relatively free from air pollution.

* * *

The control of air pollution is complicated by its complexity of cause. No longer is smoke control enough. Serious consideration must be given both to visual pollutants such as fly ash and soot, and to invisible pollutants such as nitrogen oxides, sulfur oxides, hydro-carbons, aldehydes, acids and radio-active contaminants.

* * *

Just where the medical profession fits this picture is frequently a tender point with a slowly arousing

¹ Dr. Clarence Mills is Professor of Experimental Medicine at the University of Cincinnati.

citizenry. Right or wrong, there is a general feeling that leadership in a problem so intimately connected with public health should develop among those most interested in its preservation: the doctors. It is heartening to report that in scattered areas throughout the United States the profession has already made significant contributions. Research in many of the problems is being actively conducted by local and national groups, as well as by public health teams from various states. A solution will come about only from a co-operative civilian and professional effort. How high we value public health may dictate the course. In the meantime, the people, as they should, look to the medical profession on all levels, local, state, and national, to dedicate their efforts to the solution of one of the most pressing problems in public health that this nation has ever faced.

r-r-R-R-R—CRASH!

The *Virginia Medical Monthly* for November, 1952, calls attention to an evil which no doubt has been discussed in county medical societies any number of times, usually with the result that some society representative has a little talk with the purveyors of ambulance service, after which there is great improvement,—for a while. Then the temptation to make sensational runs overcomes prudence and we're off again in a cloud of dust with one foot on the siren and the other on the accelerator. Somehow it reminds one of Kenneth Grahame's famous Toad. As in Indiana, even so in fair Verginny:

HASTE BY AMBULANCE MAKES WASTE

The recent accident at Ryland and Grace Streets in Richmond in which a private car driven by a lady marine was totally destroyed, a city ambulance was overturned, and a water plug broken off causing a flooding of the street and great inconvenience to a number of citizens on their way to work, poses the question of how fast should an ambulance go? Fortunately no one was injured in this accident. The property damage amounted to \$2,300. A second ambulance found the patient pacing the sidewalk in front of his house. His only complaint was a headache. He was taken to the emergency room of the hospital and given a couple of aspirin tablets.

The difference between safe driving and reckless driving amounts to probably 5 minutes, or at the most

10 minutes, in reaching the destination if all goes well. We can imagine cases of stab wounds, deep razor wounds of the throat, asphyxia from gas poisoning in which minutes could make a difference in the outcome. As a matter of fact the great majority of injuries can be handled very well by a neighbor or bystander, now that first aid training by the Red Cross has become well nigh universal. In cases of asphyxia, gas poisoning, and electric shock, there is no need of rush treatment by ambulances, since they are best treated by the local fireman who has the training and equipment, including pulmometer and antidotes for poisons, for emergency treatment.

Just how many injuries would be well handled by a neighbor might provoke an argument; but certainly the time saved on short runs in the city by driving more than 40 miles an hour can amount to very little in 95 per cent of cases,—possibly we should say in 99.44 per cent. Figure it out yourself: 2 miles at "60 per" takes 2 minutes, at "40 per," only 3 minutes. Less thrilling, yes, but also less damaging, my friend.

County Society Officers to Meet January 11



W. L. McGrath

Highlighted by the luncheon address of William L. McGrath, Cincinnati, the 28th Annual Conference of County Medical Society Officers promises to be one of the most outstanding programs of this representative group of the Indiana State Medical Association.

The morning and afternoon session will convene in the Riley room of the Claypool hotel on Sunday, January 11. Registration opens at 9 o'clock. An address of welcome will be given by Paul D. Crimm, M.D., president of ISMA, at 9:30. At 9:45 Dr. J. William Wright and Dr. Harold C. Ochsner of the Committee on Public Policy and Legislation will conduct a discussion on the coming session of the Indiana General Assembly after which the executive secretary, James A. Waggener, will talk on "Association Procedures." A social hour will precede the noon luncheon.

The speaker, Mr. McGrath, has had an unusual business career over a period of 32 years with the Williamson Heater Company and is now its president. He has served as president of Cincinnati Chamber of Commerce, president of Cincinnati Industrial Association, has been national president of the Society for the Advancement of Management, president of the National Warm Air Heating and Air Conditioning Association.

In 1949 he was appointed employer member of the American delegation to the International Labor Organization Conference at Geneva, Switzerland. As vice-chairman of this employer delegation he participated in four yearly conferences, the last in May and June, 1952. He will discuss the possible influences of this organization on the medical profession and his address is informative and in some respects startling.

A discussion of all phases of press and professional public relations practices will be conducted at the afternoon session by Lawrence Rember, AMA public relations field service director. There will be ample time for everyone to participate in discussion of each subject during the day and the meeting is open to all doctors.

The program will be concluded by mid-afternoon with the presentation of a brief comic program.



President's Page



FELLOW MEMBERS OF THE I.S.M.A.:

ALTHOUGH the earth is round, frequently it is considered to be in a h— of a shape. This vernacular deduction has been oracled by many from the time Magellan sailed around the world. The moral and economic levels, which are the vogue, influence opinion to the extent that, at times, the world does seem to be in such a state of shapelessness, especially if you cannot stomach inhuman totalitarianism.

People of today retain the same anatomical pattern as those who lived in the world of yesteryears, but their lives are molded by centuries of civilization and shaped by the struggle for existence. All of us are delivered on earth naked and void of everything except potential essentials. All are born selfish and non-cooperative but thanks to the processes of education we attain varying degrees of unselfishness and cooperation. Likewise, we acquire a certain amount of brotherly love which often is not more than skin deep or too often dependent upon remuneration of filthy lucre or upon a friendship of "I'll scratch your back if you scratch mine." And whether born poor or rich, the essay "to stay off relief" acquires us substance, which ultimately vanishes through the medium of taxes and death. With a lethal exodus in the offing for all, folks continue to harangue and to hate and to hoard. Although one hesitates to estimate the number of persons who are in search of pelf purely for self, certainly too few carry on a livelihood always mindful of a quotation from the Sermon on the Mount "Whatsoever ye would that men should do to you, do ye even so to them."

Undoubtedly this quotation is responsible in part for the effort put forth to convert the world into One World. Theoretically the idea has merit but practically it cannot be achieved until more people adhere to the Golden Rule; until Christian, Jew, Moslem, et al, live up to their religious tenets every day in the week, instead of just on Sunday; until every race strives to preserve the identity of every other race; until each nation is capable of settling its own domestic problems. "Peace on Earth, Good Will Toward Men" will never be universal until we either educate or we exterminate those who desire to control where we live, where we work, and where we worship.

In the meantime, no group of citizens are in a better position to improve the American Way of Living and the American Way of Doctoring than the practitioner of the healing art. We must, by example, show our patients and fellow practitioners the ethical way to practice medicine. We must continue our prime objective of getting the patient well. We must answer the call of the sick by day or by night, in order to prevent patients from saying "Last night I could not locate a physician and had to call a chiropractor." We must stick to issues and not indulge in personalities. We must avoid professional backbiting and remember that "the wise man holds himself in check while the fool runs on ahead." All of which adds up to the fact that organized medicine has been, is, and always will be duty bound to practice the Golden Rule in order to do its share in designing the destinies of the practice of medicine whether it be in One World or in a divided world. And may nineteen hundred and fifty-three find us reconsecrating those resolutions which will make America strong regardless of the shape of the world.

Paul D. Grimm M.D.

P. S. Once upon a time an old Indian prayed "Oh, Spirit, help me not to criticize my friend until I have walked in his moccasins two weeks."

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

YOUR HEALTH

Are you one of the people who take better care of your machinery and your livestock than you do of your own personal health?

Maybe your face gets red as you ponder this question. The editor's face got red when he wrote it.

It is a fact, substantiated by the Indiana State Medical Association, that most Hoosiers—just like Americans in general—refuse to take their health seriously until they are carried into a hospital or forced to call their physician. Health is the most precious possession any of us have, and it is very hard to fully regain when we lose it or start losing it.

The seriousness of our apathy toward health care was pointed out recently by Dr. J. William Wright, Sr., president of the state association, when he testified before the President's Commission on Health Needs of the Nation. He vigorously opposed the "insidious propaganda" for compulsory health insurance and urged instead that efforts be directed toward encouraging local health programs, local initiative and local voluntary efforts to awaken the people to the ease and low-cost with which they can meet their own health or medical problems.

The Guide is in thorough accord with Dr. Wright. We suggest that many readers might like to have a copy of his statement before the President's Commission in Detroit last Sept. 23. This can be obtained by writing to the State Medical Association, 1021 Hume Mansur Building, Indianapolis 4, Ind.

—*The Indiana Farmers Guide*

IN RECOGNITION OF HIGH SERVICE

George A. Ball's record of selfless service in the cause of better medical care and education makes the endowment of a chair in his honor at the Indiana University School of Medicine a most fitting tribute.

The James Whitcomb Riley Memorial Association has joined with Indiana University in establishing a George A. Ball Visiting Professorship In Surgery in recognition of the Muncie philanthropist's many years of effort and personal generosity in behalf of the Riley Hospital for Chil-

dren, Indiana University and medical education in general. Appropriately, he was notified of the endowment yesterday, his 90th birthday, by members of the Riley Memorial Association board of governors and representatives of the I.U. School of Medicine.

Mr. Ball, the lone survivor of the five brothers who founded the famous Ball Brothers Company, was one of a group of persons who more than 30 years ago conceived the idea of a children's hospital in memory of James Whitcomb Riley. He is charter member of the memorial association and an original member of the board of governors. He has done much invaluable work in behalf of the hospital and the medical school, and he and his family have made large contributions to both.

The chair in surgery is, indeed, a merited recognition of Mr. Ball's continuing services, as is the fact that more than 100,000 children have benefited from his good work for Riley Hospital.

—*Indianapolis Star.*

WHEN ONE IS TWO-THIRDS

The other day we referred to a pamphlet by Frank E. Holman, former president of the American Bar association, demonstrating the need of a constitutional amendment to protect Americans against United Nations "treaty law." Mr. Holman makes the point that the United States is unique in that the Constitution makes treaties "the supreme law of the land" without further implementing legislation.

"The state department," he says, "suggests that the President would not recommend and the senate would not ratify a treaty which adversely affected American rights. Can we risk this in view of what has been going on?"

Mr. Holman's answer is that we cannot, and he offers, among other examples of the slipshod, casual, and almost jocular treatment accorded treaties in the senate, an amazing incident which occurred last June 13. On that day, because no one had demanded a roll call, only two senators were present. Sen. John Sparkman of Alabama, recently Adlai Stevenson's Democratic running mate in the Presidential election, was presiding. The only other senator present was Edward J. Thye of Minnesota, a New Deal Republican.

Sparkman announced to Thye that, without objection, the senate would proceed to the consideration of executive business. As the Congressional Record puts it, Sparkman then "laid before the senate messages from the President," referring to various nominations, which Sparkman then referred to appropriate committees. Sparkman then called up two conventions and one treaty, relating to consular conventions between the United States and Ireland and the United States and Britain. The texts of these various undertakings cover 11 pages of fine print in that day's record of proceedings.

Sparkman, presiding, cast the only vote on these three instruments, then ruled that "in the opinion of the chair, two-thirds of the senators present" had concurred and the undertakings had been duly ratified. Sen. Thye said nothing. He conceded later, "I did not object."

Here we have the ludicrous situation in which the presiding officer of the senate casts a lone vote on an important international instrument and then rules that he, in his own person, represents a majority and constitutes two-thirds of the senators present and voting.

When treaties and similar undertakings are dealt with thus frivolously in the senate, it behooves the people of the United States to exercise great caution in determining the character of treaties and international conventions that reach the senate. Especially is this true when United Nations conventions would have the effect of overturning the basic law of the land.

—*Chicago Tribune*

PENSION AND HEALTH

General Eisenhower's endorsement just before the election of a pension plan for self-employed workers pointed up one of the inequities of the income tax laws. But there are others.

The proposition that a doctor, lawyer, dentist, writer, grocer or druggist or anyone else who is professionally or in a business way outside the Government's "security" programs ought to be able to put something aside for his later and less productive days seems to us to be a fair one. Most of the arguments we have heard against it aren't very convincing. Some say that it will discriminate against workers who can't deduct social security payments from their taxes. It seems to us this sort of argument is easily answered;

all these pension plans suggest is deferment of income and deferment of taxes upon that income until it is to be used. Workers covered by social security could be granted the same sort of tax relief.

Drafters of the planned economy are, of course, against such ideas because they make people less dependent upon the Government. The planners like the inequities in the income tax laws because such inequities are aids to more and more Government control.

Among the inequities in the income tax law is one which sooner or later reaches all taxpayers. It also has helped provide arguments for socialized medicine.

The administration defeated at the polls last week favored socialized medicine, and the income tax laws, whether designed to do so or not, provided bait for its fishing among the voters. Medical attention is costly and to offer it "free" is to make a very attractive offer—even though more and more people are learning that nothing is "free" when dispensed by a government which must tax its citizens to provide services.

Under the present law, a taxpayer cannot deduct medical expenses such as doctor's bills, dental costs, pills, plasters, X-rays or treatments of any kind unless the costs are in excess of 5 percent of the taxpayers' adjusted gross income.

As an example, a man whose income taxes are figured on a gross income of \$3,600 a year finds that during that year he has had to pay out \$190 in medical costs. The Government will allow him to deduct but \$10, and he must pay a tax on the \$180. Good use of the taxes on that \$180 could be made by any man whose adjusted gross income is \$3,600 annually, and there are millions of taxpayers in that class.

General Eisenhower is as much against the idea of socialized medicine as the Truman Administration was for it. But just being against it isn't enough. Positive treatment can cure the evils of socialized medicine's false appeal. One way to cure it would be to allow all taxpayers to deduct all expenses attached to health. This would also cure one of the inequities of the income tax law, for it seems to us to be an unfair burden to have to pay taxes for trying to get well.

—*Wall Street Journal*.

NEW SPRAY ON PLASTIC DRESSING MAY PROVE EFFECTIVE FOR GENERAL USE



Official Air Force Photos, released by Department of Defense

In the photograph above, left, the burned area of a hand is ready for spraying with the new "aeroplast". Center photograph shows hand sprayed with "aeroplast" to a thickness of approximately five thousandths of an inch. During healing, the wound can be inspected at a glance. If necessary the plastic can be peeled off intact without injuring the wound and a new coating applied quickly. It adheres only to dry, healthy skin area.

At right, Captain Daniel S. J. Choy, USAF, holds two six-ounce bombs, or the amount considered necessary to treat burns on 25 per cent of the body. T/Sgt. James Edwards, Jr., holds the amount of regular dressings that would be needed for similar treatment. It consists of 2 pounds of ointment, 60 yards of bandages, 30 yards of adhesive tape, and gauze pads.

A PROJECT of the United States Air Force's Research and Development Command, "aeroplast" was developed by Captain Daniel S. J. Choy, USAF Medical Corps, the Aero Medical Laboratory, Wright Air Development Center, Dayton. Captain Choy was named project officer in August 1951 when ARDC authorized the Aero Medical Laboratory to use its facilities to develop such a dressing.

With the assistance of Protective Treatments, Inc., Dayton, a suitable modified vinyl plastic was developed under Air Force research contract. The plastic met fully the requirements set up by the Air Force covering impermeability to bacteria, transparency, elasticity and flexibility, ease of application, and stability in storage.

Air Force medical officers recently completed an eight-week program testing the dressing on many types of injuries and surgical cases. It is planned to conduct further tests in hospitals throughout the United States to determine if the new dressing is suitable for standard usage. As a result of earlier tests, AF doctors believe "aeroplast" may be effective clinically as a general surgical dressing.

In addition to the advantages pictured above, important possible reasons for its use, especially in the case of large scale disasters, are: the dressing can be applied quickly by a relatively untrained person, is less expensive than gauze, is portable and quantities can be stored indefinitely in a minimum of space.

EMERGENCY MEDICAL CARE IN TIPPECANOE COUNTY

R. B. DUBOIS, M.D.

D. M. JONES, M.D.

P. W. ROTHROCK, M.D.

Lafayette

THE Tippecanoe County Medical Society, in an effort to improve public relations and offer better medical service to the community, appointed a committee to work out a plan for furnishing emergency medical care to the people of Lafayette and the surrounding area.

The plan which seemed to be the one that would best handle the situation was worked out by the committee and adopted by the society.

The workings of the plan are explained in the following letter which was sent to each member of the Tippecanoe County Medical Society.

Newspaper ad size 2 columns x6½ Inches

NOTICE

THE TIPPECANOE COUNTY MEDICAL
SOCIETY WISHES TO ANNOUNCE THE
OPENING OF TWO NEW SERVICES.

EMERGENCY MEDICAL SERVICE

If you cannot locate your physician or
have no physician and need emergency
medical service:

DIAL 2-3323

PHYSICIANS' EXCHANGE

For help in locating your physician:

DIAL 2-3375

CONSULT YOUR NEW PHONE BOOK
FOR THE LISTING OF THESE TELE-
PHONE NUMBERS.

To Members of the Tippecanoe County Medical Society:

Two new services are being installed by the County Medical Society, namely: THE PHYSICIANS' EXCHANGE and the EMERGENCY MEDICAL SERVICE.

These services will go into effect on December 12, 1952. There will be two telephones installed.

A signout sheet will be kept at the hospital at the Home Hospital switch board:

PHYSICIANS' EXCHANGE—DIAL 2-3375 and
EMERGENCY MEDICAL SERVICE—DIAL 2-3323

There will be four newspaper ads announcing this new service. They will run in the Lafayette Journal and Courier on Dec. 19, 1952, Dec. 26, 1952, Jan. 2, 1953, and Jan. 9, 1953. The new phone book will contain an ad that will appear in the yellow section, advertising these two services. The telephone books will be distributed Jan. 12, 1953.

Telephone ad ½ column

EMERGENCY MEDICAL SERVICE

If you cannot locate your physician or have no
physician and need emergency medical service:

DIAL 2-3323

PHYSICIANS' EXCHANGE

For help in locating your physician:

DIAL 2-3375

The above services furnished by the Tippecanoe
County Medical Society.

Placards for display in doctors' offices will be sent to each doctor. Placards will be posted on the bulletin boards in all chart rooms of both hospitals.

Placard for chart rooms

WHEN YOU WISH TO LOCATE A DOCTOR BUT HIS OFFICE OR HOME PHONE DOES NOT ANSWER, PLEASE PHONE PHYSICIANS' EXCHANGE. THEY WILL TELL YOU WHERE TO REACH HIM OR WHO IS TAKING HIS CALLS.

PHYSICIANS' EXCHANGE

DIAL 2-3375

A signout sheet will be kept at the hospital switchboard and all doctors must notify the switchboard whenever their phone is uncovered: (Where they may be located, when they will be back, who is taking their calls.)

Two doctors will be assigned each week for emergency medical service to serve from Monday 8:00 A.M. to the following Monday at 8:00 A.M. All members of the Tippecanoe County Medical Society will be expected to serve on this service with the exception of (1) Members of Purdue Health Service, (2) Those retired from active practice, (3) Those to be excused because of poor health, and (4) Those members whose offices are located outside of Lafayette and West Lafayette. Physicians will be notified on the Wednesday before their service starts on Monday. In case of previously made plans to be out of the city, your week of service can be assigned upon your return.

The girls at the Home Hospital will have definite instructions as to how to answer the two phones. The public is to be informed of the services. To make it a success, the DOCTORS MUST KEEP THE GIRLS INFORMED OF THEIR WHEREABOUTS.

MEMBER OF
DOCTOR'S EXCHANGE

When you are unable to locate me by phoning my office or my home, please dial PHYSICIANS' EXCHANGE 2-3375 and they will tell you where to reach me or who is taking my calls.

Signed-----M.D.

Instructions for girls at switchboard for Emergency Medical Service Phone.

ANSWER THIS PHONE: "EMERGENCY MEDICAL SERVICE." Ask the person calling whether he has tried to locate his own physician. If he is unable to locate his own physician or has no physician and needs emergency medical treatment, give him the names and phone numbers (office and home) of the two physicians on call.

Instructions for Physicians' Exchange Phone

ANSWER THIS PHONE: "PHYSICIANS' EXCHANGE." Ask what doctor they are trying to locate. Refer to the "Sign Out" sheet and tell the person where he can locate his doctor or who is taking his calls.

All doctors who have clinical practices will have an extra listing of the physicians' exchange telephone number in the white section of the phone book.

Between October 6 and October 17 a representative of the directory company will contact all doctors in order to ascertain how he wishes to be listed in the YELLOW section of the phone book—listings in the YELLOW section are at the individual doctor's own expense. The directory company recommends that the doctors

list the exchange number under the individual names in the yellow section.

The emergency medical service phone will be listed on the front page of the phone book along with FIRE, POLICE, and FBI.

INDIANA ASSOCIATED TELEPHONE	
CORPORATION	
EMERGENCIES	
FIRE	POLICE
FBI	
EMERGENCY MEDICAL SERVICE	
2-3323	

The cost of running this service, will be in the neighborhood of \$1600 for the first year.

BREAKDOWN

Listings in white section.....	\$354.00
Physicians' Exchange Phone.....	141.50
Emergency Medical Phone.....	141.50
Advertising in yellow section.....	159.00
Newspaper ads	120.00
Bonuses for Home Hospital Switchboard girls..	720.00
Placards for offices. (Not determined).....	?
Placards for chart rooms. (Not determined)---	?
Estimated Total.....	\$1635.00

Doctors who have active clinical practices and have their offices in Lafayette or West Lafayette will be billed for \$25.00 a year. Doctors whose practices do not require a listing of the Physi-

cian's Exchange number in the white section of the phone book, will be billed for \$19.00 per year. Doctors who are members of the Tippecanoe County Medical Society and who have their offices outside the city limits of Lafayette and West Lafayette will be billed for \$12.50 per year.

On or about December 15, 1952, you will be billed by Mr. T. E. Berg, Manager of the Home Hospital, for either \$25, \$19, or \$12.50. Please pay this promptly. Mr. Berg will handle all of the finances and if there is money left over at the end of 1953, you will be billed for less for 1954.

The committee felt that the success of the plan would require the cooperation of the doctors' wives and the doctors' secretaries. With this in mind, a copy of the letter explaining the plan was sent to each doctor's wife and to each doctor's secretary.

The establishment of the plan was made possible by the co-operation of the representatives of the telephone company, and the willingness of Mr. T. E. Berg, Manager of the Home Hospital, to allow the use of the hospital facilities.

It is felt that the plan will work in our community. It has been received well by the members of the society and with their help in running it, it is believed that public relations in this community will be definitely benefited.



THREE ASSOCIATE EDITORS ASSUME DUTIES ON STAFF OF THE JOURNAL



Dr. Bickel



Dr. Montgomery



Dr. Johnson

*W*ITH this issue of *THE JOURNAL* of the Indiana State Medical Association the editorial staff is increased by the addition of three recently named associate editors whose wide experience makes them particularly valuable in the assembling and presentation of scientific material for *THE JOURNAL*. All have been members of the editorial board.

Stephen L. Johnson, M.D., Evansville, left, specializes in internal medicine, certified by the American Board of Internal Medicine. He is a 1933 graduate of the Indiana University School of Medicine. During World War II, Doctor Johnson was one of the 39 Indiana physicians who staffed the 32nd General Hospital sponsored by the Indiana University School of Medicine.

Lall G. Montgomery, M.D., Muncie, center, is a graduate of the University of Manitoba Faculty of Medicine, in Winnipeg, 1929. He is certified by the American Board of Pathology, is a member of the College of American Pathologists and of the American Society of Clinical Pathologists. Doctor Montgomery has been a resident of Indiana since 1935 coming to this state from Rochester, Minnesota. He is pathologist at Ball Memorial hospital, Muncie.

David A. Bickel, M.D., South Bend, right, is a native Hoosier, attended Indiana University, then graduated from the I. U. School of Medicine in 1921. He served internship and residency at Western Reserve University hospitals. Doctor Bickel is certified by the American Board of Obstetrics and Gynecology and is a member of the Central Association of Obstetricians and Gynecologists. He is a member of the Board of Governors of the American College of Surgeons, is chief of staff of Memorial Hospital, South Bend, and vice-president of the South Bend Medical Foundation. Doctor Bickel has contributed several articles to *THE JOURNAL* and to national medical publications.

SERVING THE CHILD EFFECTIVELY THROUGH THE SCHOOL HEALTH PROGRAM

DONALD A. DUKELOW, M.D.*

Chicago

IT IS easy to develop a school health program for the program's sake or for our own sake, rather than for the sake of the children we are serving. Health officers and school administrators and an occasional teacher or health coordinator may brag about "my health program." Communities which compete with each other in terms of which had the best health program in their school or their community, do it on the basis of the number of personnel employed, the number of pamphlets distributed, the number of physical examinations performed, the number of teeth filled, but rarely, if ever, in terms of the number of children who were directed into the paths of healthful living by the skillful ministrations of a teacher, a counsellor, a physician, a nurse, or possibly by the group working as a team. It is quite important that we have both the team work concept and the concept that what we are doing is not a school health program, *per se*, but a program for the improvement of a whole generation, collectively and individually.

We glibly divide the school health program up into pieces and assign those pieces to individuals. We assign what we call health teaching or health education to the teacher. Environment or healthful school living, we assign to the administrator and the custodian and possibly those who operate the lunchroom and the locker rooms. Another area called health services, is the domain of the nurse and the physician. We try very hard to keep these separate. It would be undesirable if a physician should teach or if a teacher should serve in the area which is normally served by the custodian. If a nurse should enter the classroom or a teacher should

advise a child on health practices, it would be a serious usurpation of the other's prerogative.

This, of course, is an exaggeration. I have intentionally exaggerated in order to make the point. We are dealing with children and children cannot be divided into exclusive categories and classifications. They cannot be physical one minute, emotional another, intellectual a third. We must take children as they come, we must serve their health needs as they arise, we must make use of the "teachable moments" when they occur and we must do all of this in an environment which lends itself as an example of what we are trying to teach.

Books, Experience Both Needed

Patterns of healthful living in our children must be based on sound health instruction which gives these children fundamental concepts which they can use in making discriminating judgments regarding health matters both now and in the future. Many of these concepts must be taught out of the book or out of the experience of the teacher. Others of them can be illustrated by incidents that occur in the classroom, such as the near-sighted youngster who must sit in a front seat, the child who is hard-of-hearing, the habit of eating at lunch time and between meals, courtesy and safety practices on the playground, the cut finger, and the bruised knee, the cold, measles and all of the other thousand and one instances that provide an opportunity to point out a lesson.

These "teachable moments" should include the contacts the child has with the nurse serving the school, with the visiting teacher, with the family physician and dentist and their associates or with the school physician. The child can soon develop the habit of making use of most of these instances as learning experiences, because he will utilize for his own information, those

* Consultant in Health and Fitness, Bureau of Health Education, American Medical Association. This paper was presented before the Regional School Health Conferences at Hanover College, Indiana, October 8 and Franklin College, Indiana, November 12.

teachable moments which may not happen to have an adult associated with them. As you can see, health instruction, the establishment of habit patterns, and the development of attitudes go far beyond what happens in school hours in the classroom under the immediate supervision of the classroom teacher.

Healthful school living permeates a good deal of the child's experience. Many of the schools, particularly in the rural districts, are not attractive. They are old, they are in poor repair, and they are not well designed. Nevertheless, a little effort on the part of an inspired teacher can make a considerable difference in both the physical and the emotional atmosphere that exists in and around that school. Simple soap and water cleanliness, a few flowers, orderly grounds, a clean playground and a pleasant personality, all help to develop that appreciation for property which, in time, leads to appreciation of person and ultimately to habits of cleanliness, of self-protection and of interest in the rights of others that make for healthful living.

In the school room the most constant factor in the environment of children is the teacher. The emotionally stable teacher who has a mature personality, will have a well-ordered, happy, emotional atmosphere in his classroom. Good physical health in addition produces an ideal example for children to follow. This can be contrasted with the frustrated, emotionally immature individual who is constantly enjoying poor health, and setting anything but a good example of physical and mental health for the children in his class. It is quite important for administrators and boards of education to be alert to the emotional climate in the classrooms and to help those unfortunate individuals whose physical or mental health is less than adequate. This is the least that can be done for the protection of the children who must be exposed to these health conditions for the better part of that school year.

The home, also, is an important factor in the environment of the child and it also determines, to some extent, the environment of the school because the school is what the parents demand. Where there is a predominance of substandard homes with parents who are uninformed or disinterested in school matters, one is likely to find an inadequate school, because such families will not support a better one. When such a situation

exists, the adult education program must be intensified in order that the school environment as well as the other factors of the school health program will be improved.

"Service" Misunderstood

A third area is health service. Too frequently, this area is misunderstood because of the word "service." The usual connotation of "service" is something that is done to or for another. In our health service programs in the school we frequently make the mistake of doing a lot of things "to" and "for" children, instead of helping children to do things for themselves.

Schools often have physicians come into the school to examine the children. This is done because it is easier, the children are all in one place and do not have to be gotten to offices about the town, the school has a more complete control over the services that will be rendered by the physician, there is a record of the examination at the school and a number of other factors, all of which make it seem to be very desirable. However, in school systems where this is carried to the logical conclusion, we find children who have no memory of being in a physician's or a dentist's office, who know nothing about the services that are normally offered by the private practitioner, who have no idea of what these services might cost, or how to go about attaining them, all because the school has provided these children with their health services up to graduation.

It seems very important that children learn about the community's resources in the field of health service. They should know something about physicians, how physicians practice, the kinds of services that they offer, about what those services cost, what the hospitals do and why, what are dentists, how are they consulted and for what purposes, and the cost of their services. It may be necessary for a school system to employ a physician or to appoint a physician to advise the school on health matters. The school may want to supplement the health services of family physicians with a consultation for which they are responsible. It would seem however, that wherever possible, the services of the family physician should be utilized for individual pupil care in order to teach the child the normal health service resources that are found in each community. Where, for financial or other reasons, a family does not have a

family physician, services that simulate those of the family physician can be provided through the local social agencies or physicians designated by the county medical society to perform these services.

But the physicians and the dentists are not the only ones concerned with health service. The nurse serving the school is certainly an ally of the physician. She is able to interpret to him her observations of the home and school problems of individual children. She can interpret the physicians' findings and recommendations to the home and the school. The teacher likewise is an important person in the health service field because of his continuous daily observations of children. It is he who is in the strategic position to observe the changes in appearance and in behavior that may be the beginning of illness or the development of chronic deficiencies that a physician might miss unless he had a suggestion of the slow change that is taking place over a period of weeks or even months. It is also the teacher, working under the direction of the nurse, who does the screening tests for vision and hearing and the measurements of height and weight that are important laboratory experiences in education, but at the same time are important information on health status. Quite frequently the bus driver and the custodian perform health services, particularly in the form of mental health. They are the only males in the lives of some fatherless children and are looked to and respected by some as substitute fathers. They, too, should be alert to the part that they are playing in molding the health and emotional attitudes of children that they contact.

Coordinate Services

We have been talking about serving the child effectively. So far it has been necessary to discuss areas of service and individuals performing that service one at a time. This must now be molded into a unified program with a unified objective in order to reach the higher levels of effectiveness. The physician, the dentist, the health officer, the nurse, the administrator, the teacher, the bus driver and the custodian each, in his own way, helps the school health program to be effective. The school, the health department, the medical society, the dental society and the interested voluntary

health agencies each operate their own school health programs. To do the job effectively requires a coordination of all of the areas of service in the school health program. Also each person and agency must be ready to help the other in those areas where the professional field of one closely touches the professional field of another. Obviously, the physician will want to advise the nurse and the teacher on the observation of children and on the channels for referral. Obviously, the teacher will want to counsel with the physician, the nurse and the family and many of the agencies on effective methods of health teaching. Certainly the custodian and the bus driver, as well as the administrator, will be getting ideas on environment from many people in the community. With all of these people working together it is sometimes wise to bring children into the picture and learn from them their hopes and ambitions and interests in order that all of this may more effectively become a part of their lives.

One method used by many to improve the coordination of the various professions and agencies concerned with school health is the development of school health councils, or school health committees in community health councils. These serve as a forum for the exchange of opinion, as a nucleus for interprofessional cooperation and as the center for planning future developments that contain the influence of all who are interested.

Summarizing, it might be said that the effectiveness of the school health program will be improved when that program is child centered rather than adult centered and is designed less to serve the child than to help the child learn how to serve himself. The effectiveness can be increased when the various professions and agencies concerned learn to work together, to consult with each other, and to fit the contribution each can make to those of the others in such a way that there is a unified school health program rather than one for each agency and each profession. Furthermore, this working together can be made easy when a forum, by whatever name you may wish to call it, is established in which there can be this exchange of opinion, this basic planning that leads to effective execution of programs, well designed to accomplish the objectives for which they were intended.

STATE NURSES' ASSOCIATION TO ASK LEGISLATURE FOR SCHOLARSHIP FUNDS

A bill sponsored by the Indiana State Nurses Association has been prepared and will be introduced in the 1953 General Assembly. The bill provides for a scholarship fund through which Indiana registered nurses may secure scholarships to prepare themselves for positions in teaching, supervision, or administration in nursing.

It is believed that Indiana needs a scholarship bill for the following reasons:

1. The Indiana Nursing Survey, published in 1952 and supported financially by the Indiana State Medical Association, shows that instructors in most of Indiana's schools of nursing are not educationally prepared for their jobs.

2. Only one of Indiana's 24 schools of nursing now has full national accreditation. Only 14 have temporary accreditation.

National accreditation has frequently been withheld from our schools because of the scarcity of full time faculty personnel, too heavy faculty load, etc. In many Indiana schools of nursing there is also a marked failure to provide for all students the clinical experiences long regarded as essential to basic preparation. In Indiana, in the four basic clinical areas—medical, surgical, obstetric and pediatric nursing—only a third of the supervisors have had additional preparation beyond their basic nursing programs; among clinical instructors in these areas only 24% have had preparation for their specialized jobs. Student nurses can only perform in a manner in which they are taught hence good instruction is essential if our schools are to prepare good nurses.

3. Dramatic evidence of the need to improve schools of nursing is also found in the performance of Indiana student nurses in the national test-pool examinations. These are as follows:

- a. Medical nursing—37 states rate higher than Indiana
- b. Surgical nursing—22 states rate higher than Indiana
- c. Obstetric nursing—29 states rate higher than Indiana
- d. Nursing of children—34 states rate higher than Indiana

e. Communicable disease nursing—28 states rate higher than Indiana

f. Psychiatric nursing—37 states rate higher than Indiana

4. It is recognized that poor schools cannot attract qualified teaching personnel until a nucleus of qualified faculty is available to provide a working basis for educational programs; in this respect, Indiana's schools cannot hope to secure faculty personnel from outside the state to any appreciable degree.

5. Hospitals which own and operate the majority of Indiana nursing schools cannot offer scholarships to faculty personnel because of increasing hospital costs.

6. Other states are securing scholarship aid which is providing prepared faculty with the result that nursing education is concurrently being upgraded in other states which will in turn place Indiana even lower on the comparative national level unless immediate action is taken.

The contents of the proposed bill are as follows:

1. It provides for \$100,000 annually to be available for the Nursing Scholarship Fund which is to be administered by Indiana University.
2. The Indiana State Nurses Association is to create a scholarship committee which will determine the eligibility of the scholarship applicants.
3. Any Indiana registered nurse who is a resident of this state and lacks funds to pursue her education in teaching, supervision or administration of nursing will be eligible to apply for such scholarship.
4. The nurse must agree upon receipt of such scholarship to accept a position in Indiana for two years following completion of the course of study.
5. Up to \$3,000 may be granted for each scholarship and such scholarship may be used in any educational institution offering a course in nursing education that is approved by Indiana University.

STATE BOARD ANNUAL REGISTRATION LAW: PROVISION FOR LICENSEES IN SERVICE

Chapter 254—Acts of 1947

SECTION 1. That every person who now holds, or may hereafter hold, a valid and unrevoked certificate for a license to practice the Healing Art in any form or manner, granted by either the State Board of Medical Registration and Examination or the Board of Registration and Examination of Indiana, shall be required to register with the Board of Medical Registration and Examination of Indiana, in the form and manner determined by said Board, during the month of July and not later than the last day of August, immediately following the effective date of this Act, which registration shall be for the period ending June 30, 1948. Each person as above indicated shall, annually thereafter, on or before August 31st of each year, be required to register with said Board. Each applicant for registration shall submit with his application the sum of Five (\$5.00) Dollars as the annual registration fee if he resides within the boundaries of the State of Indiana. All applicants residing outside the boundaries of the State of Indiana shall submit the sum of Ten (\$10.00) Dollars as the annual registration fee; Provided, that no registration or fee for registration shall be required of any holder of a certificate on or before the month of July of the year following the year within which such certificate was issued. Failure of any such certificate holder to register and comply with the provisions of this Act shall operate automatically to cancel his certificate, and any license issued thereunder and the continued practice after the cancellation of the certificate and license issued thereunder shall be considered as practicing without a license. A certificate cancelled for failure to register may be reinstated by said Board upon payment of fee for each cancelled year, current year, and a penalty fee in the sum of Ten (\$10.00) Dollars.

Chapter 108

SECTION 2. Any person who subsequent to July 1, 1940, has been or who shall hereafter prior to July 1, 1953, be lawfully inducted into military service, and who at the time of such induction was or is a licensee of the State of Indiana, may within six months after the termination of such military service by discharge other than dishonorable, apply for and be entitled to a renewal license* without examination, re-examination, fine or penalty, notwithstanding the fact that his license or last previous renewal license shall have expired during such military service; and the officer, board or department empowered by law to issue such renewal license is hereby authorized to issue the same without examination, re-examination or the exaction of any fine or penalty. The issuance of such renewal license* shall in all other respects be subject to the provisions of law relating thereto: Provided, however, That when any renewal license is issued after the beginning of the license year, the annual license fee shall be reduced by one-twelfth for each elapsed month of such year.

****Explanatory Note:** Wherever the term "renewal license" appears in Chapter 108, the term "annual registration" shall apply in lieu thereof to licensees of the Board of Medical Registration and Examination of Indiana.

The date of issuance of the certificate by the Board of Medical Registration and Examination of Indiana is the legal determining date, **not** the date upon which license is issued by the circuit court clerk upon surrender of the certificate to that office.

Resident and non-resident status is determined by the licensee's legal residence at the time of entering military service.

The licensee who does not comply with annual registration law and allows his license to remain

cancelled during period of military service, and who is eligible for reinstatement in accordance with provisions of the foregoing Chapter 108 of the Acts of 1951 Indiana General Assembly, shall make application for reinstatement by submitting to the Board of Medical Registration and Examination of Indiana a photostatic copy of military discharge papers, together with fee

for that current year, the fee reduced by 1/12th for each elapsed month of that year, and upon receipt of same license will be reinstated. If such licensee requests reinstatement prior to discharge from military service, same shall be effected by complying with regular provisions of the annual registration law, Chapter 254, Acts of 1947.

Psychiatric Communications Privileged

The A.M.A. Committee on Mental Health calls attention to a recent court decision which is of interest to psychiatrists particularly and to physicians generally since it refers to the doctor-patient relationship.

The decision, rendered by Judge Harry M. Fisher of the Circuit Court of Cook County, Chicago, is published in full in the November 22 issue of the A.M.A. Journal.

In this case, the patient was receiving psychotherapy under the care of Dr. Roy R. Grinker at Michael Reese Hospital, Chicago. The attorney for the patient's husband requested that the court subpoena Dr. Grinker and the hospital records for testimony in a suit for alienation of affection in which the husband charged the defendant with stealing his wife's (the patient's) love. The wife had separated from the husband and had instituted suit for divorce.

Both the hospital authorities and Dr. Grinker refused to testify before a notary public on the theory that the communications between the patient and the psychiatrist were or should be privileged.

Judge Fisher ruled that all confidential communications between the patient and the psychiatrist are privileged. He therefore denied a motion to compel the hospital to produce its records and to compel the psychiatrist to testify.

—Secretary's Letter

American Medical Association

News Notes



OFFICIAL delegates from the Indiana State Medical Association to the interim session of the American Medical Association are pictured in the insert, lower left corner, above. From left to right they are: Karl R. Ruddell, M.D., Indianapolis; Cleon A. Nafe, M.D., Indianapolis; Wendell C. Stover, M.D., Boonville; and E. S. Jones, M.D., Hammond. Sessions were held in Denver, Colorado, from December 2 through December 5.

Reports from American Medical Association headquarters disclose that the December meeting—the sixth annual clinical session—was the largest medical meeting ever held in the Rocky Mountain area. Registration for the three-day meeting totaled 6,733.

Preceding the scientific sessions a one-day public relations workshop was conducted. ISMA Executive Secretary James A. Waggener attended this and remained for the clinical sessions.

The larger photograph, above, shows the House of Delegates in session at Denver.

A full and official report will be carried later in *THE JOURNAL*.

Industrial Health Congress Scheduled for Chicago

Improving health services of our nation's working force will be the over-all theme of the Annual Congress of Industrial Health, sponsored by the AMA's Council on Industrial Health. Workers, industrial leaders and medical men will assemble for this 13th annual conference January 21-22 at the Drake Hotel, Chicago.

Highlights of the Congress include sessions on small plant industrial health services, human relations, and aspects of occupational cancer. One important session will endeavor to answer the question—how can management, labor and medicine best help maintain the health of our national work force?

On Tuesday, January 20—the day before the Congress convenes—a joint conference will be held for members of the Council and chairmen of state society committees on industrial health. Tuesday afternoon's program will be devoted to round table discussions stressing three main areas of industrial health—education, service and research. Gradie R. Rowntree, M.D., chairman of the committee on industrial health of the Kentucky State Medical Association, will preside.

Dr. Paul G. Iske, Indianapolis, was elected president of the Indiana Heart Foundation at the annual meeting recently. He will take office July 1, 1953. Other Indiana doctors who are members of the board of directors are: **Walter S. Fisher**, Columbus; **Dan L. Urschel**, Mentone; **Stuart R. Combs**, Terre Haute; **H. Glenn Gardiner**, East Chicago, and **Stephen L. Johnson**, Evansville.

Dr. E. S. Jones, Hammond, was recently named second vice president of the Industrial Medical Association, succeeding Dr. F. E. Poole, Los Angeles, who was killed in an accident.

Dr. I. L. Colvin, a graduate of Indiana University School of Medicine who has been practicing in Edon, Ohio for the last four years, has opened an office in Ashley for the practice of general medicine.

The **Diamond Anniversary of Medical Progress** and the **First Western Hemisphere Conference of the World Medical Association** will be held in Richmond, Virginia in conjunction with the Pan American Medical Confederation on April 23-25. Headquarters will be at the Hotel Jefferson with some sessions being held at Medical College of Virginia. Queries may be addressed to: Arrangements Committee, Diamond Anniversary of Medical Progress, Suite 3201, 444 Madison Avenue, New York 22, N. Y.

Indiana Doctor Speaker on A.C.S. Sectional Program

An impressive program of symposia, panel discussions, clinical conferences and medical motion pictures on practical surgical problems will open the 1953 season of Sectional Meetings of the American College of Surgeons at The Netherlands Plaza Hotel in Cincinnati, Ohio, January 19-21. This meeting is the first of eight scheduled for various parts of North and South America during the coming year. Surgeons from Illinois, Indiana, Kentucky, Michigan, Ohio, Ontario, West Virginia and Wisconsin are expected to attend, although there is no restriction on attendance from outside the area.

Dr. Carl P. Huber, Indianapolis, president of the American Academy of Obstetrics and Gynecology, will discuss "Conservative Management of Pelvic Lesions".

The executive office of the Pan-Pacific Surgical Association announces that the **Sixth Pan-Pacific Surgical Congress** will be held in Honolulu in *November 1954*.

Included in the scientific program will be sessions in all divisions of surgery and related fields, with papers presented by topflight surgeons from the Pacific Area countries.

For further information concerning the Sixth Congress or membership in the Association, doctors may write to the Pan-Pacific Surgical Association, Suite 7, Young Building, Honolulu, Hawaii.

Michigan Announces 1953 Review Courses

Postgraduate courses for practicing physicians at the University of Michigan Medical School have been announced by H. H. Cummings, M.D., chairman Department of Postgraduate Medicine, University Hospital, Room 2040, Ann Arbor. The schedule of courses follows: Internal Medicine; Diseases of the Heart, March 16-20; Electrocardiographic Diagnosis, March 23-28; Recent Advances in Therapeutics, March 30-April 2; Diseases of Blood and Blood-Forming Organs, April 6-10; Metabolism and Endocrinology, April 6-10; General Practice, April 13-24; Obstetrics and Gynecology, January 21-24 and February 25-28; Ophthalmology, April 20-21 and 22; Roentgenology, Diagnostic—April 6-10.

Newcomer to the Norways Foundation hospital resident staff is **Gordon T. Brown, M.D.** He came to Norways December 1 as a resident in psychiatry. Doctor Brown is a graduate of Indiana University School of Medicine, served an internship at San Diego Naval hospital, and was at Logansport State hospital for the last year.

Commission Assumes Responsibility for Hospitals

Ceremonies marking the end of a 35-year period in which the American College of Surgeons held sole responsibility for setting standards for the nation's hospitals were held December 6, when the plan was transferred to the new Joint Commission of Accreditation of Hospitals in a program at the John B. Murphy Auditorium, Chicago.

From now on the American College of Physicians, American College of Surgeons, American Hospital Association, American Medical Association, and Canadian Medical Association will share responsibilities of the program. Proposal for the formation of the Commission was initiated by the College in the recognition that not only surgeons but other members of organizations concerned with medical care in hospitals should participate in the establishment and enforcement of hospital standards. This combination of organizations constitutes an important milestone in the development of health services for the American people.

Dr. I. Taylor Rieger, specialist in urology, has opened an office in Bloomington. He is a graduate of Northwestern University Medical School, interned at Cook County hospital, served a two and one-half year residency in urology in Presbyterian hospital, Chicago, and has just completed two years service in the U. S. Navy.

Dr. Milton Herzberg has opened offices for the general practice of medicine in Clinton. He had been in private practice in Chicago since 1946 prior to which he had been in the army and in government service following his graduation from the University of Illinois College of Medicine.

March 3, 1953 will mark the opening day of the **9th Annual Clinical Conference of the Chicago Medical Society**. This conference is designed to be of interest to both the specialist and general practitioner. It will be held in the Palmer House. This is an activity of the Chicago Medical Society for its membership to whom no fee is charged. Those who are not members of the Chicago society are asked to register for the four days at the nominal fee of \$5.00.

"This is the time to set up your arrangements so these four days in March will permit you to come to the Palmer House and not only visit with physicians from all sections of the United States and Canada but likewise hear and see the latest developments in modern medicine," officers of Chicago Medical Society said in announcing their conference.

A course for graduate physicians in electrocardiographic interpretation will be given at Michael Reese hospital, Chicago, by Louis N. Katz, M.D., director of the Cardiovascular Department, Medical Research Institute, and associates. Classes will begin February 11 and will be held each Wednesday for 12 weeks from 7 to 9 p.m. Further information may be obtained from Mrs. Rivian H. Lewin, Administrative Secretary, Cardiovascular Department, Medical Research Institute, Michael Reese Hospital, Chicago 16, Ill.

The **First World Congress on Fertility and Sterility** will be held on May 25-31, 1953 at the Henry Hudson Hotel in New York City. This Congress is sponsored by the International Fertility Association with the cooperation of the American Society for the Study of Sterility.

Top Speakers Billed on Rural Health Program

Here's a brief glance at the "theater marque" for the Rural Health Conference February 27-28 at the Roanoke Hotel, Roanoke, Virginia.

Principal "stars" include: Friday morning—**Dr. F. S. Crockett**, chairman of the AMA's Council on Rural Health, reviewing the last seven years in "Looking Back to Look Ahead." Friday afternoon—**Dr. Carl S. Mundy**, vice chairman of the Council, explaining various phases of financing rural medical care . . . **Frank Peck**, managing director, Farm Foundation, Chicago, "The Missing Item in the Family Budget" . . . **Eugene Butler**, editor, *Progressive Farmer*, Dallas, "Problems of Medical Care in the South."

Saturday morning, a series of success and accomplishment stories—**Miss Lilyán Zindell**, administrator of Perry County Memorial Hospital, Perryville, Missouri, will tell how a community planned and constructed a community hospital . . . **Dr. Edmund Yantes**, Wilmington, Ohio, will give a follow-up on the Clinton County Survey on over-all health problems in that area . . . **Dr. B. N. Salzman**, Mountain Home, Arkansas, will present a new general practitioner's viewpoint on facing problems in a rural community . . . **Dr. Felix Underwood**, director, Mississippi State Department of Health, will discuss medical scholarships.

Winding up the conference at Saturday's luncheon, **Dr. Louis H. Bauer**, AMA president, will tell "What Medicine Is Doing"—pointing out the Association's many services to its physician-members and the general public.

Psychosomatic Forum Programs Under Way

The first meeting of the 1952-53 Psychosomatic Forum series was held in the Conference room at Veterans' hospital December 2 at which time a panel discussion on "Comprehensive management of psychosomatic disorders in medical practice" was moderated by Dr. Bennett Kraft and discussed by Drs. James H. Gosman, James M. Browning, T. F. Schlaegel, Jr. and Irving Rosenbaum, Jr.

Subsequent meetings of the group, which is a state organization for the medical profession open to M.D.'s of all types who are interested in the role of emotions in disease, will be held February 3, April 7 and June 2, according to an announcement by Dr. T. F. Schlaegel, Jr., of the Department of Ophthalmology, Indiana University Medical Center. Dr. William Province, Franklin, will present the February subject, "Psychosomatic problems in rural medical practice." Drs. J. Edward Tether and Eugene F. Boggs will be the discussants.

Dr. John H. Greist, Indianapolis, presented an address on "Psychotherapeutic Procedures Adaptable for General Practice" at the Clinical Session of the A.M.A. in Denver, December 2-5.

The first **Postgraduate Course in Diabetes and Basic Metabolic Problems** to be conducted by the American Diabetes Association will be offered under the direction of Charles H. Best, M.D., on January 19, 20, 21, 1953, at the University of Toronto, Canada.

Over 30 lectures and round-table discussions have been planned as well as a social evening. The course is open to non-member physicians as well as members of the American Diabetes Association, but the number of registrants will be limited to 100. Fees are \$20 to members, \$40 to non-members. Details of the three-day program and registration and hotel information may be obtained from J. Richard Connelly, Executive Director, American Diabetes Association, 11 West 42nd Street, New York 36, N. Y.

Prominent Speakers to Address Heart Seminar



General Armstrong

Physicians from all parts of the state are invited to attend the annual postgraduate symposium on the heart, sponsored cooperatively by the Indiana Heart Foundation and the Indiana University School of Medicine. The Heart Seminar will be held in the afternoon and evening of February 10 at the Indiana University Medical Center.

Speakers will include General George Armstrong, Surgeon-General of the United States Army, Washington, D. C.; Dr. Walter T. Zimdahl, instructor, University of Buffalo Medical School, Buffalo, New York; and Dr. Paul Dudley White, Boston, Massachusetts.

Doctor White was clinical professor of medicine, Harvard Medical School, from 1946 to 1950; physician in charge of cardiac laboratory and clinics, Massachusetts General Hospital, 1911-1948; president of American Heart Association, 1941-42; executive director, National Advisory Heart Council, and chief advisor, National Heart Institute, since 1948. This year Doctor White was awarded the Distinguished Service Medal by the American Medical Association.

Doctor Zimdahl also is attending physician at the cardiac clinic at Buffalo General Hospital and a member of the American Board of Internal Medicine. He is a director of the Chronic Disease Research Institute, secretary of the Western New York Heart Association and director of the Cardiac Kitchen recently opened by that association.

Several inquiries as to the **use of mycolipin**, a new material for the making of serologic tests for syphilis which is being developed by Dr. Paul Fugazzotto of the Indiana State Board of Health have been received, the state board

announces. Dr. Charles Rein, New York University, and Dr. Reuben L. Kahn, University of Michigan, have received a supply for experimental work. Dr. Peter Krag, World Health Organization, Geneva, Switzerland, has requested a copy of the article on the subject presented by Dr. Fugazzotto at the recent meeting in Cleveland of the American Public Health Association.

Dr. Gaetano Correo, who has been a practicing physician and surgeon in Chicago for 14 years, has opened an office in Indiana Harbor, where he has also established residence. He is a graduate of Northwestern University Medical School, Chicago.

Council to Discuss Age Problems, Public Health

Problems of the aging and legislation affecting public health will be the theme for the semi-annual meeting of the Indiana Advisory Health Council to be held January 29 at the Indiana State Board of Health, according to arrangements made by the executive committee of the council.

Dr. J. H. Clevenger, Muncie, representative of the Indiana State Medical Association on the council, is chairman of the executive committee. Prof. L. E. Hoffman, associate director of the Agricultural Extension Service, Purdue University, is vice-chairman, and Mrs. Royer K. Brown, Carmel, of the Indiana Federation of Women's clubs, is secretary.

Other members of the committee include Roy Fenn, Tell City; Dr. George S. Bond, of the Indiana Heart Foundation; John V. Barnett, Indiana State Chamber of Commerce; Anson Thomas, Indiana Farm Bureau, and Mrs. Montgomery S. Lewis, former chairman of the council.

Deaths

Jesse J. Johnson, M.D., 79, died November 29 in his Milltown home after a three months illness. His death came just two weeks after the entire community had paid him tribute with a public celebration in observance of his 49th year of practice. A native of West Fork, where he was born in 1874, Doctor Johnson received his degree in medicine from the Kentucky School of Medicine, Louisville, in 1903, started practice in West Fork, went to Sulphur and then to Milltown where he had been for many years. He had served as Crawford County Health Commissioner, was a member of both state and national medical associations.

Herbert E. Bland, M.D., dean of Sullivan county physicians, died November 30 following a long illness. He was 79 years old. Doctor Bland had practiced medicine for more than 50 years in Fairbanks, establishing residence there in 1898 immediately after his graduation from Louisville Medical College. The Sullivan County Medical society had honored him last spring for his many years of service to the county. In 1948, Doctor Bland received his 50 year pin from the Indiana State Medical Association. He had been in retirement because of illness.

Clint C. Sourwine, M.D., Brazil, 70, a Clay county physician and surgeon for nearly 50 years, died December 5. He was serving as Clay county and Brazil health commissioner and deputy coroner. For many years, Doctor Sourwine was associated with his father in the operation of the Sourwine hospital in Brazil. He served for a year during the Mexican border uprising and spent three years as an officer

overseas during World War I. He was a graduate of Indiana Medical College, School of Medicine, Purdue University, Indianapolis. A member of the Clay County Medical society, he had served as secretary in 1915-16, and was also a member of the Indiana State and American Medical Associations.

Ernest E. Cahal, M.D., 69, who had been a practicing physician and obstetrician in Indianapolis for many years, died after a brief illness on November 18. A graduate of Indiana University School of Medicine in 1914, Doctor Cahal took postgraduate work at Johns Hopkins University and the Lying-In hospital, New York City. He was on the staffs of the Methodist, St. Vincent's and St. Francis hospitals. Doctor Cahal was a member of Indianapolis Medical Society, the Indiana State and American Medical Associations.

Francis M. Dickason, M.D., 84, retired Bluffton physician, died November 11 in the Veterans' hospital, Fort Wayne. A native of Wells county, Doctor Dickason practiced at Petroleum for a number of years before moving to Bluffton. He had been in retirement for several years.

Stanley Lee Brown, M.D., Hammond, died December 8. Doctor Brown maintained an office in Chicago for many years but was a member of the Indiana State Medical Association as well as Illinois State Medical Association. Born in 1885, he was a 1909 graduate of Northwestern University Medical School.

A.M.A. WASHINGTON OFFICE NEWS

EISENHOWER AND TAFT AGREE ON COMMISSION TO STUDY HEALTH, WELFARE PROBLEMS.

President-Elect Eisenhower and Senator Taft, the dominant Republican in the Senate, have agreed that *a commission should be set up to study all federal-state relations in the field of aids and grants, including health and welfare problems.* If the idea receives Congressional approval, it probably will mean "freezing" health and welfare programs at their present level for the next year while the commission carries on its investigation. Some commission members would be appointed by the new President, the remainder by House and Senate leaders. Senator Taft said he expected it to be "predominantly" Republican.

Senator Taft discussed the suggestion following his meeting in New York with the General, where all major legislative issues were taken up. Although he said everything still was in the "thinking out" stage, the Senator emphasized *the General was in agreement with him that the commission method appeared the best approach to the problem.* During the campaign Gen. Eisenhower had said he favored an extension of social security. "If we set up the commission, we will hold what we have in these fields but we probably won't enact any legislation that costs more money," the Senator said, "because there's no money left to spend until we can reduce heavy military costs."

Asked whether creation of the commission would mean no action next year on the waiver of premium section of the social security law (H. R. 7800) the Senator said he couldn't answer flatly "yes" or "no" but he assumed that inasmuch as this feature was not now in operation it probably wouldn't be put into effect in advance of the commission's findings (under this provision, the pension rights of OASI beneficiaries would not be reduced by periods of unemployment if they were found to be permanently and totally disabled. Under a compromise, the provision was written into the social security law at the last session, but it cannot become operative without further Congressional action.)

Although the commission would be expected to come up with recommendations covering health, social security and housing questions, Senator Taft said it would not confine itself to these fields but would make a searching study of all federal-state financial relationships. He was hopeful the commission would be able to suggest ways of blocking off or reserving certain areas of taxation for the states, *so the states themselves would be able to provide more welfare services and not have to turn to the federal government for help.*

Red Cross Assumes Cost of Producing Gamma Globulin

American Red Cross has announced that it will assume costs of producing gamma globulin, an action which will result in several changes in the National Blood Program. Because gamma globulin and serum albumin can be processed from the same whole blood, Defense Department and Federal Civil Defense Administration will begin storing serum albumin; both had been storing blood plasma until the Red Cross announcement. While Red Cross *will assume cost of producing gamma globulin for the nation, it will not undertake its distribution and allocation.* How this gamma globulin is to be distributed—there will be no charge for it—still has to be decided. State and Territorial Health Officers, meeting here this week, are expected to work out some system for distribution, and make their recommendations to the Office of Defense Mobilization.

Another problem is that of matching supply with demand. Because gamma globulin is considered effective in prevention of paralysis due to poliomyelitis, the public demand for it is expected to far out-reach supply by early next summer. Although increased blood donations are expected as a result of the publicity on the new Red Cross campaign, there is little or no possibility of producing, in the immediate future, all the gamma globulin that will be desired.

DOCTOR DRAFT DEBATED DURING 3-DAY MEETING OF ASSOCIATION OF MILITARY SURGEONS.

The doctor draft and its future were the dominant theme of the Washington meeting of the Association of Military Surgeons (Nov. 17-19.) But left unanswered were two important questions: 1. Just how much time do military doctors spend on care of dependents? 2. Can sufficient personnel be obtained for the services on a voluntary basis? The law expires June 31 unless extended by Congress.

The debate was touched off when **Rear Admiral Lamont Pugh**, Navy Surgeon General, declared that the main objection to military medicine—and the main attraction of civilian medicine—was “simply a matter of easier, quicker and bigger money—avarice, a better albeit a fanciful and possibly ephemeral opportunity to get rich quick.”

Promptly, the AMA issued a statement declaring that when patriotism is at stake the doctor, like everyone else, is always ready to serve his country. Two days later, **Dr. Louis H. Bauer**, AMA President, told the military surgeons that the Admiral's statements were “an unjustifiable slur on the American Medical Association and the vast majority of the medical profession, and were calculated not only to cause resentment but to hurt the very cause in which he and all the rest of us are interested.” Admiral Pugh replied that his remarks were not intended as a slur on the AMA or the profession but at an element of physicians and dentists who insist military services be made more attractive.

With this part of the debate disposed of, the issues became specific. Dr. Bauer, noting that the medical services are still suffering from unfavorable reactions from World War II, offered a four-point program. It proposes: (1) launching by the armed forces of a campaign to tell civilian physicians what the services offer, along with a frank admission of the unappealing parts, (2) determination by the services of how much time is spent by doctors treating military dependents, (3) a study of whether enough doctors can be obtained on a voluntary basis for the services, and (4) even closer contact between military and

civilian medical professions, including expansion of the consultant system.

Dr. Bauer concluded: “We should work in cooperation and with full understanding of our various problems and not at cross purposes. It is our Army, our Navy, our Air Force and our country. What affects civilian medicine affects military medicine and what affects military medicine affects civilian medicine.”

This theme was heard again when **Dr. Melvin A. Casberg**, chairman of the important Armed Forces Medical Policy Council, described military procurement of doctors as “American medicine's problem” which must be solved by joint efforts. He said the council was “convinced beyond a shadow of doubt that a law in some form is a must.” He made a plea that the question of care of dependents not be raised at this point because it would “cloud the issue.”

The final word in the debate came from **President Truman**. Addressing the awards dinner, he said “the trouble, sacrifice and inconveniences caused by the present necessity of drafting doctors might be obviated—or at least lessened—if our supply of civilian doctors were not so limited. This is something for the profession to think about. We must train far more doctors”

Civil Defense Issues Manual on Matching Funds Program

Federal Civil Defense Administration has issued a comprehensive manual to guide state and local civil defense officials in getting matching federal funds for health, special weapons, and other protective programs. The publication, *Federal Contributions*, is available at \$1 a copy from the Government Printing Office, Washington 25, D. C.

The manual goes into details. For example, it recommends specific medical supplies and equipment for a first aid station, for a 200-bed improvised hospital and for a blood donor operation. It also sets forth legal and policy limitations and procurement procedures.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

November 18, 1952

Roll call showed the following present: C. J. Clark, M.D., chairman; W. L. Portteus, M.D.; Paul D. Crimm, M.D.; W. H. Howard, M.D.; Wemple Dodds, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump, attorney; James A. Waggener, executive secretary; Robert J. Amick, field secretary.

Guests: Mr. George Nuffer, Extension Service, Purdue University; C. H. McCaskey, M.D.; Joseph F. Ferrara, M.D.

Mr. Nuffer discussed a proposed plan for 4-H Club Health Program. After a full discussion of the matter, in which it was brought out that the committee felt the phrasing of the questions was improper to obtain the results desired, the following committee was appointed by the chairman of the Executive Committee to work on rewriting the questions: Drs. Paul Crimm, Wemple Dodds and Frank Ramsey.

Membership Report

Number of members November 18, 1952 ... 3,745*
 Number of members November 18, 1951 ... 3,656
 Gain over last year ----- 89

* Includes 77 in military service (gratis)
 133—\$10.00 members (residents and interns)
 250—senior members
 1—honorary member
 62—members, dues remitted by Council

Headquarters Office

Upon motion of Drs. Dodds and Howard the executive secretary was given permission to purchase a dictating machine.

The field secretary reported on his activities and told of the expanded use being made by the county medical societies of the film service now offered by the association.

Treasurer's Office

Upon motion of Drs. Crimm and Portteus, the George S. Olive Company is to be employed for the annual audit of the books.

Annual Session, French Lick,

October 19, 20 and 21, 1953

Exhibit rules. After discussion of the exhibits of the 1952 session, it was determined wise to change the rules for the 1953 session. Upon motion of Drs. Portteus and Dodds, companies will be permitted to exhibit who have one or more

Council accepted products and who may be approved for exhibit at the discretion of the Executive Committee.

Business meetings. Upon motion of Drs. Portteus and Dodds, the Executive Committee, Council and House of Delegates will meet on Sunday, October 18, prior to the opening of the annual session on October 19.

Legislative Matters

National—The executive secretary reported on the regional legislative conference held in Chicago on November 7, 1952.

Local

Workmen's compensation act. Following a discussion by Dr. Crimm of the workmen's compensation matter which is expected to come before the 1953 legislature, the committee, upon motion of Drs. Portteus and Dodds, moved that the association support the A.M.A. policy and that this matter be referred to the Council at its next meeting for further discussion and action.

Organization Matters

(1) *Resolution on cooperation between medical and dental professions.* Dr. McCaskey discussed the proposed resolution to come before the A.M.A.

Upon motion of Drs. Crimm and Howard the Executive Committee went on record as agreeing with the context of the material and copies of the resolution, together with this action, are to be forwarded to the A.M.A. delegates from Indiana.

A letter from the Academy of General Practice was read, expressing their thanks for space at the 1952 annual convention.

American Federation of Medical Centers. The matter of the proposal for the establishment of the American Federation of Medical Centers was discussed and a letter from the Noble County Medical Society on this subject was read.

Following a discussion of this matter the committee agreed this should be studied further and that the executive secretary should contact the A.M.A. headquarters for additional information.

Elaboration of medical ethics. A proposal from the Rock Island County Medical Society of Illinois regarding the Iowa resolution concerning elaboration of medical ethics was discussed and upon motion of Drs. Crimm and Howard the headquarters office is to contact the headquarters office of the American Medical Association requesting that this matter be clarified in the Principles of Medical Ethics, as well as the portion of the ethics concerning workmen's compensation cases.

Nurses' workshops. The committee asked the president to select five physicians to act as group

(Continued on Page 60)



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advisors for the nurses' workshop which is to be held in Indianapolis on December 4 and 5, 1952.

The Journal

Report on advertising was accepted by consent:

Total, November, 1951	-----\$2,294.07
Total, November, 1952	-----\$2,079.00

Future Meetings

By consent, it was agreed that Dr. E. W. Mericle also should attend the Public Relations Conference in Denver on December 1.

The chairman of the Civil Defense Committee was given permission to attend the Regional Civil Defense meeting in Kansas City on December 13 and 14, on motion of Drs. Portteus and Crimm.

The chairman of the Industrial Health Committee was given permission to attend the Annual Congress on Industrial Health to be held in Chicago on January 20 to 22, 1953, on motion of Drs. Crimm and Dodds.

The executive secretary and the chairman of the Committee on Medical Education and Hospitals were given permission to attend the annual meeting of the American Medical Education Foundation in Chicago on Sunday, January 25, 1953, on motion of Drs. Crimm and Dodds.

There being no further business the committee adjourned to meet again at 11:00 a. m., Sunday, December 14, 1952, in the Columbia Club, Indianapolis.

COUNCILOR DISTRICT MEETING

Dr. Lee Hickman, Hammond, will serve the **Tenth District Medical Society** as president during 1953; Dr. Leo Cooper, Gary, will serve as secretary and Dr. J. Robert Doty, Gary, has been named Tenth District Councilor. The new officers were elected at a meeting held jointly with Lake County Medical Society, in a Robertsdale restaurant. The program for the meeting was arranged by the Indiana Academy of General Practice.

Dr. Paul D. Crimm, president of the Indiana State Medical Association, was the luncheon speaker at the meeting of the **Thirteenth Councilor district** held November 19 in the Hotel Elkhart, Elkhart. At the dinner meeting which concluded the day's program, Dr. W. W. Bauer, Director of the Bureau of Health Education of AMA and editor of "Today's Health" spoke on "Health Education."

District officers for the coming year were elected following the luncheon. Dr. John E.

Luzzader, New Carlisle, was named president; Dr. Otis Bowen, Bremen, vice-president; Dr. O. E. Wilson, Elkhart, was reelected secretary-treasurer; Dr. K. L. Olson, South Bend, reelected councilor and Dr. G. O. Larson, LaPorte, reelected alternate councilor.

Other speakers on the program were, Dr. James L. Wilson, professor, Department of Pediatrics, University of Michigan, Ann Arbor; Dr. Stanley Gibson, emeritus professor of pediatrics, Northwestern University Medical School, Chicago; Dr. Ben W. Lichtenstein, clinical professor of neurology, University of Illinois, Chicago. The morning program consisted of a seminar on "Neoplasms of the Lung."

LOCAL SOCIETY REPORTS

At the annual meeting of the **Delaware-Blackford County Medical Society** the following officers were elected to serve until the next annual meeting which will be held in November, 1953: President, Dr. John R. Hurley; President-elect, Dr. Thomas M. Brown; secretary, Dr. William B. Adams; treasurer, Mr. Milton Gustafson; board of censors for three years, Dr. Fletcher M. McDowell. Delegates to the 1953 state convention are Drs. Clay Ball, Kemper Venis, and Edward F. Wierzalis.

Wells County Medical Society elected Homer B. Annis, Bluffton, president; Jack L. Eisaman, Bluffton, vice-president; Richard P. Yoder, Bluffton, secretary-treasurer; delegate to state convention, Truman Caylor, and alternate delegate, Doctor Annis at a meeting held November 17 in the Caylor-Nickel Clinic building. Members viewed a film on "Obesity" and made plans for their Christmas party in the home of Dr. Truman Caylor. Auxiliary members were to plan the entertainment.

Dr. E. Vernon Hahn, Indianapolis, was the speaker for the November 19 meeting of **Parke-Vermillion County Medical Society** which was held in the Vermillion County hospital in Clinton. The topic of his paper was

(Continued on Page 62)

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

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"Epilepsy". Dr. W. D. Britton, acting secretary, reported 18 members present. Three guests, who attended the meeting, will all become members of the society. They are Drs. Milton Herzberg, formerly of Chicago; Paul Pickett, formerly of Worthington, both of whom are practicing in Clinton and Dr. E. T. McGilvray, who has been a medical missionary in India and is now on the staff of the Indiana State Sanatorium, Rockville.

Twenty-two members of the **LaPorte County Medical Society** heard a paper on "Problems of the Adopted Child" by Mr. Valjeck, superintendent of the Mishawaka children's Aid Society, at their November 20 meeting which was held in Peacock Inn, Rolling Prairie.

W. D. Gatch, M.D., Indianapolis, spoke on "Carcinoma of the Breast" before the meeting of the **Henry County Medical Society** on November 20. Thirty-one members attended the meeting which was held in the Henry County hospital. Announcement was made that Dr. L. H. Wiatt has located in Knightstown and that the Christmas party and annual election was scheduled for December 18 at the New Castle Country club.

Members of the **Camp Atterbury Medical Society** heard Dr. Thomas Horwitz, Indianapolis, discuss "Poliomyelitis at their November meeting in the conference room of Building 1030. A general discussion followed the talk.

Dr. Murray DeArmond, Indianapolis, was the guest speaker at the November meeting of the **Terre Haute Academy of Medicine**. His topic was "The Mechanism and Interpretation of Post Partum Reaction." He was made an honorary member of the group.

Ten members of the **Fulton County Medical Society** held a noon meeting, December 5, in Woodlawn hospital, Rochester. Dr. Slater Knotts, Rochester, was elected secretary of the society for 1953.

A symposium on "Disorders of the Feet in Both Children and Adults" was presented to 78 members of **St. Joseph County Medical Society** at the November meeting held in Northern Indiana Children's hospital. Doctors participating in the discussion were: R. M. McDonald, R. H. Denham, Jr., L. M. Bodnar, R. L. Parsons, K. T. Knode, and M. S. Friedman.

Members of the **Cass County Medical Society** held a dinner meeting November 17 in St. Joseph's hospital, Logansport, after which Dr. Foss Schenck conducted a business meeting. A recording of a telephone seminar on "Urinary Tract Infections" followed. Dr. Robert Garrett, I. U. School of Medicine, moderated the program and others who participated were Drs. Robert Howell, Wendell Shullenger, John Scott, all of the I. U. School of Medicine, and Dr. William N. Wishard, associate professor of genitro-urinary surgery.

Dr. John J. Farris and Dr. C. Philip Fox, both of Washington, were elected president and secretary, respectively, of the **Daviess-Martin County Medical Society** at a dinner meeting held on November 25 in the home of Dr. A. G. Blazey, Washington. Thirteen members were present. The next meeting will be held on January 6, at 8 p.m., in the Daviess County hospital.

Forty members of the **Hancock County Hospital staff** and the **Hancock County Medical Society** held a joint dinner meeting on November 24 in the hospital. A film on atonic subjects was shown and two representatives of Blue Cross, Mr. Fly and Mr. Hume, discussed matters of mutual interest with the groups.

Twenty-three members of **Lawrence County Medical Society** met in Dunn Memorial hospital, December 3, for a noon luncheon and at that time elected the following officers for the coming year: Dr. Donald M. Kerr, Bedford, president; Dr. L. E. Benham, Bedford, secretary.

(Continued on Page 64)

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Noble County Medical society members elected Dr. A. L. Fipp, Rome City, president to serve during the coming year; Dr. K. D. Sneary, Avilla, vice-president; Dr. Frank W. Messer, Kendallville, secretary-treasurer. Eight members were present for the December 2 meeting which was held in the offices of Drs. Williams and Messer. They also selected as delegates to the Indiana State Medical Association, Dr. J. R. Nash, Albion, and Dr. B. H. Puls-kamp, Wolcottville. A telephone seminar concluded their program.

At the November meeting of the **Orange County Medical Society** held in West Baden Springs hotel Dr. N. E. Keseric, French Lick, was named president; Dr. B. E. Sugarman, French Lick, vice-president; Dr. Keith Hammond, Paoli, secretary-treasurer. Seven members were present for the dinner meeting. On December 2, the society members met again in the West Baden Springs hotel for dinner after which six members and two guests heard Dr. George W. Pedigo, Jr., Louisville, talk on "Antibiotics".

Ripley County Medical Society members entertained their wives, nurses and office assistants at the Lakeside Country club, Milan, December 9 at a dinner meeting. Speakers were Robert Amick, ISMA field secretary, who discussed legislative problems, and L. E. Converse, representative of Blue Shield and W. K. Teiser, representative of Blue Cross. Mr. Converse and Mr. Teiser discussed hospitalization plans. Dr. William McConnell, Sunman, was named president of the Ripley County society and Dr. Henry W. Conrad, Milan reelected for his third term as secretary-treasurer. The next meeting of the society will be held February 10 in Osgood when two films "Without Fear" and "Backfire" will be shown.

Dr. John E. Komoroske, East Chicago, has been named 1953 president of the Lake County Medical society; Dr. William Troutwine, Crown Point, president-elect; and Dr. Harry Stimson, Gary, secretary. The election was held at the November meeting in Robertsedale.

Dr. James G. Kidd, Roann, was named president of the **Wabash County Medical Society** at a dinner meeting held December 10 in the Sheller hotel, North Manchester. Dr. William E. Pearson, Wabash, will serve as vice-president during 1953 and Dr. George Bal-sbaugh, North Manchester, was named secretary-treasurer. The next meeting of the society will be on January 14.

Grant County Medical society members held their November dinner meeting in Emley's restaurant, Marion, and at the business meeting following elected Dr. Charles F. Abell, Marion, president; Dr. William Koontz, Gas City, vice-president; reelected Dr. Russell Lavengood, Marion, secretary-treasurer; named Dr. L. H. Eshleman, Marion, delegate to the state convention and Dr. J. P. Powell, Marion, alternate delegate. The county society joined the auxiliary in purchasing a television set for the women's ward in the Grant County home. The program was concluded with the showing of a film on early diagnosis and treatment of polio by James Butler, instructor at Marion High school.

INDIANA STATE BOARD OF HEALTH Division of Communicable Disease Control

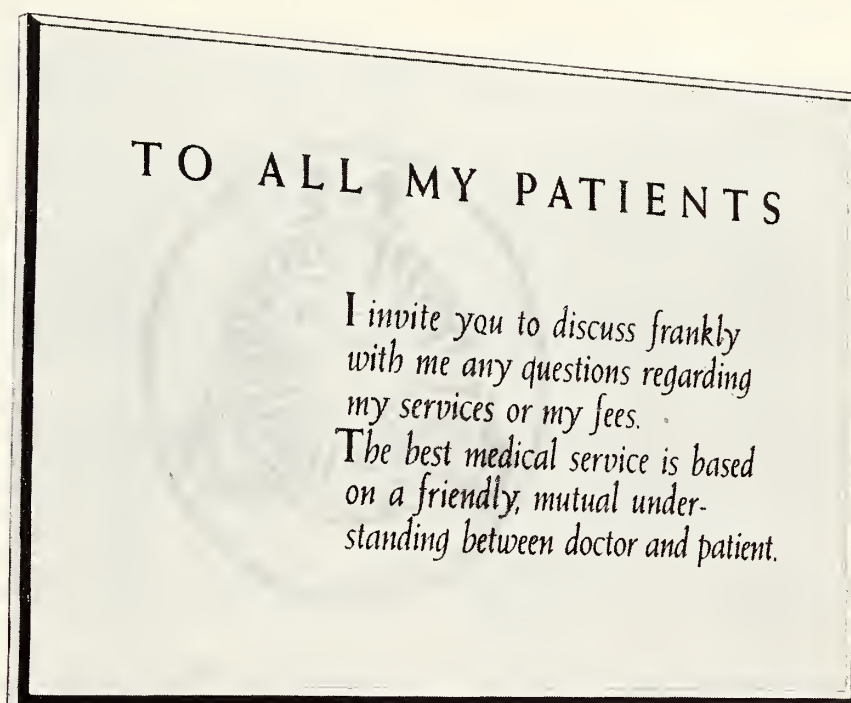
MONTHLY REPORT—OCTOBER 1952

Disease	Oct. 1952	Sept. 1952	Aug. 1952	Oct. 1951	Oct. 1950
Brucellosis	2	0	2	5	2
Chickenpox	117	13	4	45	90
Diarrhea, infectious	6	8	5	0	0
Diphtheria	1	0	2	9	15
Dysentery, shigella	3	0	0	0	0
Encephalitis	2	5	5	3	2
Impetigo	5	3	0	6	12
Influenza	69	39	4	31	32
Infectious hepatitis	16	16	12	3	2
Measles	6	17	18	39	21
Meningitis, unclassified	1	4	7	2	3
meningococcal	2	0	1	0	0
Mumps	39	19	21	80	59
Paratyphoid	1	0	5	0	0
Pneumonia	39	21	14	20	42
Poliomyelitis	407	462	317	65	156
Rabies, animal	5	12	8	24	35
Rheumatic fever	1	0	0	3	0
Rocky Mt. spotted fever	1	0	1	0	0
Rubella	4	0	1	3	2
Streptococcal infections	69	17	16	64	67
Tinea capitis	4	0	0	0	53
Typhoid fever	3	4	8	3	6
Vincent's angina	4	1	4	0	0
Whooping cough	30	43	30	96	153

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Books

BOOK REVIEWS

DOCTORS IN BLUE: The Medical History of the Union Army in the Civil War. By George Worthington Adams, Dean and Professor of History, Colorado University. 253 pages; illustrated. Price \$4.00. Henry Schuman, Inc., Publishers, 20 East 70th Street, New York 21, N. Y. 1952.

Here is a medical history of the Union Army in the Civil War, a thrilling account of how amateurs forced a reluctant military clique to accept new ideas. Such well-known doctors as Hodgen, of splint fame; W. W. Keen and S. Weir Mitchell created de novo the Medical Corps and the women of the north overcame established prejudice to form the Nursing Corps with Dorothea Dix as "Superintendent of Female Nurses." It describes a valiant struggle against a sickening mortality in spite of the absence of hypodermic syringes, fever thermometers and ambulances at a time when there was little experience in hand or instrument sterilization. Although the use of ether was 15 years old and the use of chloroform 10 years old, the medical profession was still divided on the subject of their use in emergency surgery. In the closing years of the war about 80,000 anesthetics were administered of which 76% were chloroform and with a very low mortality from its use.

No doctor could fail to enjoy this narrative.

C. N. Combs, M.D.

GYNECOLOGIC AND OBSTETRIC PATHOLOGY WITH CLINICAL AND ENDOCRINE RELATIONS.

By Emil Novak, M.D., Assistant Professor Emeritus of Gynecology, The Johns Hopkins Medical School; Gynecologist, Bon Secours and St. Agnes Hospitals, Baltimore; Fellow and Past President, American Gynecological Society. Cloth. \$10.00. Third Edition. Pp. 595 with 630 illustrations. W. B. Saunders Company, 218 W. Washington Sq., Philadelphia 5; 7 Grape St., Shaftesbury Ave., London, W. C. 2. 1952.

This is the third edition of this well known gynecologist's textbook since it first appeared in 1940. As with previous editions it is well illustrated. Almost every page presents one or more figures. Nearly a hundred new illustrations have been added, nineteen of which are in color. These visual aids appropriately placed facilitate study and combine the function of an atlas with those of a textbook.

The written presentation is brief but complete, factual, and authoritative. Each important topic is sub-titled by a bold print heading at the beginning of the paragraph so that quick reference can be made. Each chapter is closed with a bibliography. The book is completely indexed as to both subject matter and to illustrations.

Each of the thirty-five chapters have been revised with a complete rewriting of certain sections, especially those relating to carcinoma of the cervix, carcinoma in situ, hydatidiform mole and certain ovarian tumors. The last chapter is new and is titled the Common Breast Lesions of Gynecologic Interest.

Thomas M. Conley, M.D.

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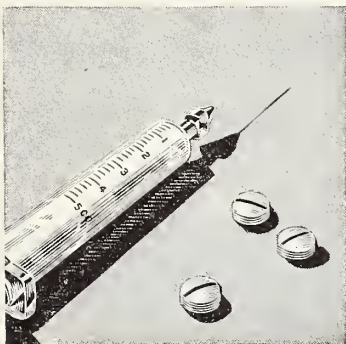
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Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

BOOKS RECEIVED

NUTRITION AND DIET IN HEALTH AND DISEASE:

By James S. McLester, M.D., Professor of Medicine Emeritus, University of Alabama; and William J. Darby, M.D., Ph.D., Professor of Biochemistry and Director of the Division of Nutrition, Vanderbilt University. New, 6th Edition. 710 pages with 14 figures and 145 tables. Philadelphia & London: W. B. Saunders Company, 1952. Price \$10.00.

OPHTHALMIC PATHOLOGY—An Atlas and Text-

book: By Jonas S. Friedenwald, Helenor Campbell Wilder, A. Edward Maumenee, T. E. Sanders, John E. L. Keyes, Michael J. Hogan, W. C. and Ella U. Owens, with the editorial assistance of Helen Knight Steward. Published Under the Joint Sponsorship of The American Academy of Ophthalmology and Otolaryngology and the Armed Forces Institute of Pathology. 489 pages with CCLX Plates. Philadelphia & London: W. B. Saunders Company, 1952. Price \$18.00.

ELECTROCARDIOGRAPHY IN PRACTICE: By Ash-

ton Graybiel, M.D., Captain, Medical Corps, U. S. Navy; Director of Research, U. S. Naval School of Aviation Medicine, Pensacola, Florida; Paul D. White, M.D., Executive Director, National Advisory Heart Council; Consultant in Medicine, Massachusetts General Hospital; Louise Wheeler, A.M., Executive Secretary, the Cardiac Laboratory, Massachusetts General Hospital; Conger Williams, M.D., Instructor in Medicine, Harvard Medical School; Associate Physician, Massachusetts General Hospital. New, 3rd Edition. 378 pages with 294 figures. Philadelphia and London: W. B. Saunders Company, 1952. Price \$10.00.

PRACTICAL DERMATOLOGY—For Medical Students

and General Practitioners: By George M. Lewis, M.D., F.A.C.P., Professor Clinical Medicine (Dermatology), Cornell University Medical College; Attending Dermatologist, The New York Hospital; Secretary, the American Board of Dermatology and Syphilology. 328 pages with 99 figures. Philadel-

phia and London: W. B. Saunders Company, 1952. Price \$7.50.

DISEASES OF METABOLISM—Detailed Methods of Diagnosis and Treatment: Edited by Garfield G. Duncan, M.D., Director of Medical Division, Pennsylvania Hospital; Clinical Professor of Medicine, Jefferson Medical College, Philadelphia, Pennsylvania. New, 3rd Edition. 1179 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1952. Price \$15.00.

STANDARD VALUES IN BLOOD—Being the first fascicle of a Handbook of Biological Data: Edited by Errett C. Albritton, A.B., M.D., Fry Professor of Physiology, The George Washington University. Prepared under the Direction of the Committee on the Handbook of Biological Data American Institute of Biological Sciences, The National Research Council. 199 pages. Philadelphia and London: W. B. Saunders Company, 1952. Price \$4.50.

SYNOPSIS OF PATHOLOGY. By W. A. D. Anderson, M.D., Professor of Pathology, Marquette University School of Medicine; pathologist, St. Joseph's Hospital, Milwaukee. Third Edition. 788 pages, 347 illustrations. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Missouri. 1952. Price \$5.00.

A 40 YEAR CAMPAIGN AGAINST TUBERCULOSIS.

By Louis I. Dublin, Ph.D., Second vice-president and statistician, Metropolitan Life Insurance Company. This monograph is the record of the contribution made by a business organization to the solution of an important medical and social problem. 115 pages. The Metropolitan Life Insurance Company, New York. 1952.

THE HISTORY OF AMERICAN EPIDEMIOLOGY.

By C. E. A. Winslow, Dr. P.H., Professor Emeritus, Yale University; Wilson G. Smillie, M.D., professor and chairman, Department of Public Health and Preventive Medicine, Cornell University, Medical College; James A. Doull, M.D., Medical Director, Leonard Wood Memorial (American Leprosy Foundation); John E. Gordon, M.D., Professor and chairman, Department of Epidemiology, School of Public Health, Harvard University. 190 pages, illustrated. The C. V. Mosby Company, St. Louis 3, Missouri. Price \$4.75.

RHEUMATIC DISEASES—Diagnosis and Treatment.

By Eugene F. Traut, M.D., Associate (Rush) Clinical Professor of Medicine, University of Illinois. 942 pages with 192 illustrations. The C. V. Mosby Company, St. Louis 3, Mo. Price \$20.00.

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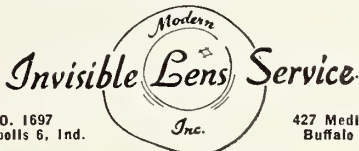
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SEX AFTER FORTY. By S. A. Lewin, M.D., and John Gilmore, Ph.D., with introduction by the Rev. Dr. Russell L. Dicks, professor of Pastoral Care at Duke University. 200 pages, with nearly 100 illustrations. Price \$3.50. Medical Research Press, 100 Park Avenue, New York 17, N. Y. 1952.

The authors of this book recently wrote "Sex Without Fear" which has enjoyed considerable popularity as a practical sex guide.

The introduction is written by the Reverend Dr. Russell L. Dicks, Professor of Pastoral Care, Duke University. The first sentence of Dr. Dicks' discussion is "Sex was discovered in our generation" true indeed, every youth makes some discoveries in the realm for sex for himself, but from what one can read, some of our ancestors had more than a passing interest in the subject. What the Reverend Doctor means to convey is: our attitude concerning sex has changed in our generation.

The book consists of a text of 16 chapters to which is added a chapter of case histories, a glossary and an index.

The authors make much of the "male climacteric" which is generally considered to be non-existent. It is true that for most male individuals over 50 virility is not what it was 25 years before. This change does not take place in any fashion that compares to the menopause in the female. It is one of the inexorable physical, mental and emotional processes associated with senescence, which is common

to both sexes. Men may not be as sexually potent after 50 as before but they may be consoled by the fact that there are no men over 50 playing professional football.

The material is plainly written and much of it concerns matters other than sex which will interest folks past 40. Emotional problems, and also the early signs of cancer are discussed. It is a book worth reading and recommending to patients desiring information regarding what to expect, and what adjustments to make for the years that follow maturity.

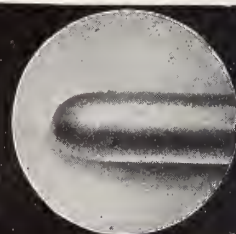
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A TEXTBOOK OF ORTHOPEDICS with a Section on Neurology in Orthopedics. By M. Beckett Howarth, M.D., Clinical Professor of Orthopedic Surgery, New York University Post-Graduate Medical School, and others. 1110 pages with 463 figures. Price \$16.00. W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa. 1952.

A basic textbook for students but scanty in operative technic for established orthopedic surgeons. The surgical treatment of deformities is entirely inadequate. For instance, it describes all varieties of clubfeet but if one had no previous experience in correcting this condition he would derive no detailed help from the book. There are many advanced treatises on the market but very few for the undergraduate and this admirably fills that vacancy.

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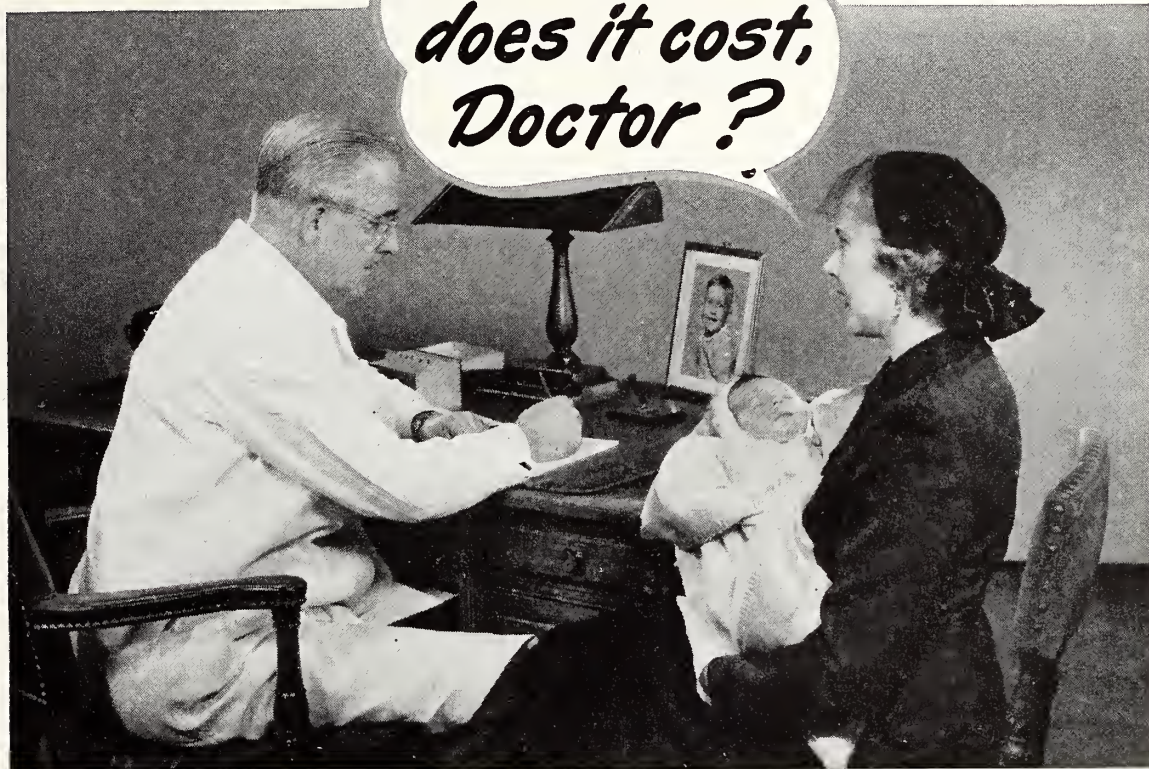
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Opinions From Here and There

Prepared for your information by the Committee on Public Policy and
Legislation of the Indiana State Medical Association

NOTE: The current AMA Washington Letter is being reproduced in full because of its timeliness and the importance to the medical profession of its contents.

The Week in Washington: The 83rd Congress is off to a fast start—so fast the government's printing presses can't keep up with it. For example, on opening day alone, 1,117 legislative measures were offered in the House, but there was space and time to mention only 342 in that day's Congressional Record. A surprising number of this first batch—a full 10 per cent—were on health and welfare subjects. This may be just a quirk, or it may mean we're in for a busy year. At any rate, we're starting our analysis of bills today, although it will be another month before we are up to date. . . . In a week or so we'll have ready a Special Report, giving complete rosters of all committees that handle medical legislation. . . . As a reminder that we have an inauguration coming up, President Truman has presented his final State of the Union message and budget to Congress. . . . But we hardly need the reminder: hotels are filling for the big week, reviewing stands already are up around Capitol Hill and the White House and there's a scurry to get the best seats, even though they're not exactly being given away.

F. E. Wilson, M.D.

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First health-welfare bills introduced cover wide range. Health and welfare bills introduced at the opening of the 83rd Congress demonstrate anew that health subjects are popular with members of Congress. Favorite subject, if number of bills introduced is any criterion, is the proposed amendment to the Constitution prohibiting the U. S. participation in any international agreement adversely affecting the rights of U. S. citizens or otherwise superseding the Constitution. They are generally known as the Bricker Resolution, which was the subject of hearings in the Senate last session but never finally acted on.

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Budget proposes continuing present rate of health spending. The outgoing administration's budget, submitted to Congress today, proposes that health and welfare expenditures for the fiscal year starting next July 1 continue at about the present rate. The total is \$2.7 billion, including Social Security and public assistance payments of approximately \$1.4 billion. For purely health programs the breakdown in millions of dollars includes: Federal Security Agency 318, Federal Civil Defense Administration 100, Atomic Energy Commission 26, Veterans Administration 717, National Science Foundation 15 and Bureau of Indian Affairs 22. Included in the FSA total is \$75 million (the same as this year) to finance the Hill-Burton hospital construction program. (*A detailed report on the Budget in relation to current spending will appear in an early edition of the AMA LETTER.*)

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Commissions, reports: Senator Taft's plan for a *commission* to look into all aspects of federal-state relations, including health and welfare grants, is making progress: a bill authorizing such a commission has been drawn up. . . . The House Select Committee to Investigate *Foundations* gives them a

clean bill in its final report, emphasizes their contributions toward elevating medical education "to a position of world eminence." . . . President Truman's *State of the Union message* was mainly devoted to international problems; referred to health matters only in two connections, the work of World Health Organization and this country's hospital construction (Hill-Burton) since 1946. . . . As anticipated, his budget message urged Congress to give careful consideration to the Magnuson recommendations. . . . The International Association of Machinists, supporting one recommendation of the *Magnuson Report*, will promote voluntary health insurance plans among the union's 800,000 members. IAM however, is not losing sight of its primary objective—national compulsory health insurance. It was this organization, incidentally, that produced "*Without Fear*," a TV propaganda film for socialized medicine shown in several states during last fall's campaign.

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Prompt reporting of respiratory disease requested. Because of high influenza rates in several U. S. military posts and scattered reports of unidentified diseases among civilians in at least two states, U. S. Public Health Service has wired state health officers to report promptly all significant data on respiratory diseases. PHS is not alarmed, however, and points out that influenza virus at Fort Leonard Wood, Mo., has been identified as A-prime type with very low mortality rate. Meanwhile, the Army has started inoculations with a polyvalent vaccine of all United Nations troops in Korea, U. S. personnel in Europe and troops at U. S. ports of embarkation for Europe and Far East. The Army Surgeon General's Office says there are no influenza epidemics as yet in Korea.

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NEW HOUSE LEGISLATION

H. R. 8 (Dingell, D.—Mich., Jan. 3). **HOSPITALIZATION FOR THE AGED.** This would amend the Social Security Act to provide federally-paid hospitalization for persons 65 and over who are covered by Old Age and Survivors Insurance and for their dependents and survivors. There would be a 60-day annual limit on hospitalization. Tuberculosis and mental cases would not be eligible, nor would domiciliary care be provided. The Federal Security Administrator would make regulations, and could operate the program within any state which failed to cooperate. States would merely act as the agents of the Administrator, functioning through the state health agency. Private insurance plans could be utilized as fiscal agents in dealing with hospitals. FSA estimates that 7 million persons immediately would become eligible, and that the initial annual cost would be \$235 million (based on an average of two days hospitalization annually). The attending physician would certify need for hospitalization. This bill is identical with legislation before the last Congress and first suggested by FSA Administrator Oscar Ewing in 1951. Also identical with this bill is H. R. 390 (Celler, D.—N. Y.), this Congress. *To Ways and Means Committee.*

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H. R. 9 (Dingell, D.—Mich., Jan. 3). **MAKING WAIVER OF PREMIUM PROVISION OPERATIVE.** This would put into effect next July 1, without further action by Congress, the section of the 1952 Social Security Amendments allowing waiver of OASI premiums for persons determined to be permanently and totally disabled. The section, now "on the books", can't become operative without additional legislation; if nothing is done, this provision expires next July 1. AMA has opposed this section because of the unusual powers it gives the Federal Security Administrator to regulate medical examinations for determining disability. *To Ways and Means Committee.*

H. R. 10 (Jenkins, R.—Ohio, Jan. 3). **TAX POSTPONEMENT FOR SELF-EMPLOYED TO CREATE RETIREMENT ANNUITIES.** Identical with the revised Reed-Keogh bills of last Congress. Generally it allows self-employed persons to deduct 10% of their earned net income or \$7,500 (whichever is the lesser) but not to exceed \$150,000 in a lifetime. These funds must be paid to a restricted retirement fund or on an annuity contract. The AMA is supporting this legislation. *To Ways and Means Committee.*

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H. R. 11 (Keogh, D.—N. Y., Jan. 3). **TAX POSTPONEMENT FOR SELF-EMPLOYED TO CREATE RETIREMENT ANNUITIES.** Identical with H. R. 10 above. *To Ways and Means Committee.*

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H. R. 25 (Rogers, R.—Mass., Jan. 3). **LENGTHENING PRESUMPTION-OF-SERVICE-CONNECTION PERIOD FOR CHRONIC AND TROPICAL DISEASES.** Would establish a presumption of service connection for chronic and tropical diseases diagnosed within 3 years after separation from military service. The present law sets a one-year limit. *To Veterans' Affairs Committee.*

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H. R. 28 (Rogers, R.—Mass., Jan. 3). **CONSTRUCTION OF 16,000 ADDITIONAL VETERANS' ADMINISTRATION BEDS.** Would authorize hospital construction dropped from the budget three years ago. *To Veterans' Affairs Committee.*

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H. R. 33 (Rogers, R.—Mass., Jan. 3). **LENGTHENING THE PRESUMPTION-OF-SERVICE-CONNECTION PERIOD FOR TUBERCULOSIS, PSYCHOSES, AND MULTIPLE SCLEROSIS.** Would consider as service connected any active tuberculosis, multiple sclerosis, or psychosis cases (or 10% or more disability) diagnosed within 3 years from the date of separation from active service, in the absence of contrary evidence. Present law provides 1 year for psychoses, 2 years for multiple sclerosis, and 3 years for all types of tuberculosis except pulmonary. Pulmonary would be included under this bill. Introduced at the request of the American Legion. *To Veterans' Affairs Committee.*

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H. R. 35 (Rogers, R.—Mass., Jan. 3). **HOSPITAL CARE AND MEDICAL TREATMENT FOR VETERANS RESIDING ABROAD.** Would permit VA to furnish hospital care and medical treatment for service connected disabilities to U. S. citizen veterans *visiting or residing* abroad. The U. S. already has reciprocal agreements with foreign countries for the protection of *visiting* veterans. Introduced at the request of the American Legion. *To Veterans' Affairs Committee.*

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H. R. 45 (Rogers, R.—Mass., Jan. 3). **PRESUMPTION-OF-SERVICE-CONNECTION FOR MALIGNANT TUMORS WITHIN 2 YEARS AFTER SEPARATION FROM SERVICE.** Present law allows one year. Introduced at the request of Disabled American Veterans. *To Veterans' Affairs Committee.*

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H. R. 46 (Rogers, R.—Mass., Jan. 3). **PRESUMPTION-OF-SERVICE-CONNECTION FOR ALL TYPES OF TUBERCULOSIS FOR WORLD WAR II VETERANS.** Present law excludes pulmonary tuberculosis. Introduced at the request of Disabled American Veterans. *To Veterans' Affairs Committee.*

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H. R. 54 (Rogers, R.—Mass., Jan. 3). **APPOINTMENT OF CHIROPRACTORS IN VA.** Would authorize appointment of doctors of chiropractic

(with degree from a school or college approved by the VA Administrator) if they are licensed to practice chiropractic in a state, territory or the District of Columbia, and have practiced for at least 2 years. Introduced at the request of Veterans of Foreign Wars. *To Veterans' Affairs Committee.*

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H. R. 97 (Burdick, R.—N. D., Jan. 3). CREDITING SERVICE IN THE ARMED FORCES OF CO-BELLIGERENTS IN DOCTOR DRAFT. To correct a situation under which alien physicians now living in the United States, many with long records, are being registered and called under the Doctor Draft Act. *To Armed Services Committee.*

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H. R. 116 (Church, R.—Ill., Jan. 3). PROHIBIT TRANSPORTATION OF FIREWORKS INTO ANY STATE WHICH PROHIBITS SALE. Provides for fine and imprisonment for importation and delivery of fireworks into any state where their sale or use is prohibited by law. Deliveries for authorized public fireworks displays excepted. A similar bill by the same author was reported to the floor last Congress. The AMA filed a statement describing the extent of fireworks casualties during the hearings. *To Judiciary Committee.*

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H. R. 173 (Rivers, D.—S. C., Jan. 3). HOSPITALIZATION AND MEDICAL CARE FOR MILITARY DEPENDENTS. Authorizes Secretary of Defense and Surgeon General of Public Health Service to provide, where practicable, hospitalization and medical care of military dependents in military facilities at rates set by the President. Facilities of all services would be available to *all* dependents under a joint utilization plan, and additional facilities would be reactivated as needed. *To Armed Services Committee.*

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H. R. 218 (Auchincloss, R.—N. J., Jan. 3). DEDUCTION FROM FEDERAL INCOME TAX OF VOLUNTARY HEALTH PLAN PREMIUMS. Providing for deduction of nonprofit health insurance costs from U. S. income taxes, predicated upon passage of the Flanders-Ives bill of last Congress which envisioned state assistance to health insurance plans. *To Ways and Means Committee.*

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H. J. RES. 7 (Auchincloss, R.—N. J., Jan. 3). A CONSTITUTIONAL AMENDMENT PROHIBITING THE MAKING OF TREATIES OR AGREEMENTS ABRIDGING U. S. LAWS OR STATE CONSTITUTIONS. Identical with the Bricker resolution of last Congress. The following measures are similar or identical: H. J. RES. 25 (Dolliver, R.—Iowa); H. J. RES. 28 (Dondero, R.—Mich.); and H. J. RES. 79 (Smith, R.—Wis.). *To Judiciary Committee.*

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H. RES. 13 (Bolling, D.—Mo., Jan. 3). PROBLEMS OF THE AGING. Authorizes a select House committee of seven members to investigate status of older persons with respect to (a) employment, (b) health education and community services, and (c) the federal government's responsibilities toward this group. Other identical measures introduced the same day are: H. RES. 17 (Elliott, D.—Ala.) and H. RES. 20 (Heselton, R.—Mass.). *To Rules Committee.*

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H. RES. 34 (Rogers, R.—Mass., Jan. 3). INVESTIGATION OF VA. Would authorize the House Veterans' Affairs Committee to thoroughly investigate the VA. (Another measure would be required to provide money for the study.) The House passed a similar measure in the 80th Congress. *To Rules Committee.*

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TREATMENT OF CHEST INJURIES

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Fort Wayne

DURING and following World War II there were numerous reports in the medical literature relating to the care of traumatic chest cases. Large series of cases were treated in centers devoted exclusively to chest problems and consequently many new ideas were tested sufficiently to prove their worth. Other methods were discarded.

It is not the purpose of this treatise to scan the entire literature. It would often be impossible to give credit for priority to the proper person. If we are able to bring forth a few new points and emphasize sufficiently principles that have proven their worth, our paper will have served its purpose.

We will not discuss thoraco-abdominal injuries at this time.

Anatomy and Physiology

An approach to the early treatment of acute chest injuries necessitates a clear conception of a few basic facts, regarding cardio-respiratory physiology.

Upon inspiration, the negative intrapleural pressure reaches 9-12 cm. of water, while on expiration the lungs are less distended and consequently their elasticity causes a negative pres-

sure of lesser degree in the pleural cavity, generally about 4-6 cm. of water.

The pleural space normally is a potential cavity only. Should a communication exist between the cavity and the bronchial tree, or should there be an opening between the pleural cavity and the outside, air will enter the pleural cavity, releasing the negative pressure and the lung will collapse from its inherent elasticity.

If the communication be large enough, the lung will fail to expand on inspiration and thus aeration will be seriously interfered with. The larger the communication, the more serious the problem.

Should inflammation fix the lung to the chest wall by adhesions, a wound opening the pleural cavity will not result in collapse of the lung. If the mediastinum is well fixed by previous inflammation, pneumothorax will not result in mediastinal shift, even if the lung on the affected side collapses.

Classification of Chest Injuries

- I. Non-penetrating
 - A. Injuries of chest wall without pleural injury
 1. Contusion

2. Superficial laceration
3. Fractured rib
 - a. Single
 - b. Multiple
- B. With damage to pleura and to intra-thoracic viscera
 1. Hemothorax
 - a. From vessels of the chest wall, with or without fractured ribs
 - b. From aorta
 - c. From pulmonary artery and vein
 2. Pneumothorax—simple and tension
 - a. From pleural injury or rupture of emphysematous blebs
 - b. From esophageal perforation
 3. Hemo-pneumothorax from combination of above
 4. Bronchial rupture
 5. Esophageal perforation
 6. Cardiac bruise
- II. Penetrating — with or without a sucking wound
 - A. Pneumothorax (simple or tension pneumothorax)
 - B. Hemo-pneumothorax (simple or tension pneumothorax)
 - C. Lung laceration
 - D. Heart wound
 - E. Cardiac bruise
 - F. Great vessel injury

From the above classification it is evident that the possibilities and combinations thereof are many, and since treatment depends on accurate diagnosis, the practitioner must exhaust all efforts in arriving at a proper interpretation of the injury.

Diagnosis

A history and physical examination combined with roentgen examination of the chest will usually give one most of the needed information. One cannot too strongly emphasize the value of x-ray examination of the chest. The time-honored method of physical examination often leaves much to be desired. There may be a great discrepancy between the physical findings and the extent of change seen in the x-ray.

General Measures

Since many patients have lost blood from other injuries or into the chest itself, it is often

necessary to resort to blood replacement therapy to combat and prevent shock. Pain relief is necessary but it is better to err on the side of sedating these cases lightly so as not to inhibit the cough reflex.

Antibiotics are useful and should be used to prevent pneumonia and empyema.

With any chest trauma, it is of extreme importance to care for the secretions in the tracheo-bronchial tree. If these pool in the bronchi, obstruction with consequent pneumonitis and the wet lung ensue. Coughing should be insisted upon, although the patient often tries to resist all efforts because chest wall pain is severe. By constant coercion on the part of the nursing staff, many patients will raise sputum and bronchial secretions sufficiently to avoid bronchial plugging and obstructive pneumonitis. An ordinary suction machine, such as is used in tonsil surgery, is a useful instrument in aspiration of thick mucus from the pharynx as the patient coughs it up.

Children are notoriously bad coughers and must be watched carefully, lest retained secretions plug the passages and lead to pulmonary collapse. Frequently nothing less than bronchoscopic aspiration will lead to removal of secretions.

Recently Trypsin by aerosol inhalation has been employed to make secretions in the bronchial tree less viscid⁴.

One ought to try the use of steam and expectorants in cases where the patient is having trouble coughing up the thick secretions.

Our results with iodides intravenously to thin secretions have seemed to be favorable. One gram of sodium iodide twice daily intravenously in 200 cc of water has been of benefit in cases with excessively thick secretions.

Tracheal Catheterization

Occasionally it is necessary to resort to tracheal aspiration by means of a catheter inserted into the trachea through the nose⁴. By flexing the head moderately on a pillow or two and then instructing the patient to inspire deeply, one can generally slip a No. 14 or No. 16 French catheter through the nose, into the trachea, and cause violent coughing. It is well to turn on the suction machine to remove secretions loosened by the hard coughing. This has been of great help

and consequently it is seldom that sterner measures need be employed.

Non-Penetrating Injuries

Simple contusion of the chest and superficial lacerations are treated as contusions and lacerations occurring elsewhere in the body. Little need be said regarding their diagnosis, as it is evident.

Fractured Ribs

Should a blow be sufficiently great or should the chest be compressed or crushed, causing severe local pain with or without radicular extension and aggravated by deep breathing, a fractured rib is the probable diagnosis. Occasionally the injury occurs at the costo-chondral junction with separation between the rib and costal cartilage. Roentgen examination of the chest frequently fails to disclose rib fractures, and one ought not to rely too heavily on radiological confirmation since an ordinary posterior-anterior x-ray of the chest may not show fractures of the ribs if the site of injury is on the lateral side of the chest. It is common experience for autopsy surgeons to find many more fractures at post-mortem than are recorded on the roentgenogram in cases with chest trauma.

The chest ray, however, is valuable in determining whether there is injury to the lungs, whether the lungs are expanded, whether there is fluid and blood in the pleural cavity, and whether pneumothorax has occurred.

There are various methods of treating simple rib fractures. Taping is satisfactory in many cases, but in females the breasts often interfere. For taping fractures of the lower ribs, one ought to position the patient on a stool, and then snugly apply strips of 2 inch tape from the paravertebral area posteriorly on the side opposite the injury around the chest, over the fracture, ending up anteriorly across the midline opposite the side of injury. Four to six strips overlapping one another from below to above the fracture level will usually suffice. The strips should be applied in expiration, for the chest cage is maximally relaxed during this phase and consequently will be more effectively immobilized.

Should the fracture be in the upper 3 or 4 ribs, several strips extending across the clavicle from front to back will immobilize the upper chest sufficiently to relieve pain. These should be

applied in deep inspiration to suspend the ribs and prevent excursions with respirations.

When the patient will not tolerate taping, the wearing of a tight fitting vest may give the desired comfort.

When pain is uncontrollable by the above measures, one may resort to infiltration of local anesthesia into the fracture site.

Crushed Chest

When the chest is crushed, multiple ribs are fractured and the chest no longer can maintain its rigidity. Serious interference with respiration arises for during inspiration and expiration, the crushed side of the chest will give way, and paradoxical respiration ensue. Diagnosis is evident on inspection, for the injured side will be sucked in on inspiration and will move outward on expiration. Palpation discloses multiple rib fractures and a "flail" chest resembling a "bag of bones". Severe pain will be evident, the pulse will be rapid, the blood pressure is lowered, respirations will be rapid and ineffective, and cyanosis may be evident. Efforts at coughing will be resisted and non-productive.

After shock is treated with adequate blood replacement and analgesics, and lung expansion is provided for if pneumothorax is present, treatment consists in stabilizing the chest long enough for the fractures to heal sufficiently to allow the ribs to take over their function. Some advocate thoracotomy with fixation of the multiple fractures.

If taping the injured side and immobilizing it with sand bags is not sufficient to prevent paradoxical respiration, a simple method and a very efficient one is to suspend the side of the chest that is crushed. This is readily done by threading 1 to 3 steel wires under the ribs anteriorly and connecting these to overhead traction. Towel clips applied under local anesthesia directly through the skin into the ribs and connected to overhead traction will work equally well. As a rule, about four pounds traction is sufficient to restore fairly normal breathing.

If the chest is crushed bilaterally, one can suspend both sides. In some severe cases the use of a mechanical respirator, the so-called iron lung, might be of advantage, although it usually is not necessary.

Hemothorax

Hemothorax is a very frequent complication of chest injuries (70% of cases according to Edwards and Davis) and when of significant degree, it is evident due to shock, anemia, rapid pulse, and shortness of breath. With a severe degree of hemothorax, mediastinal shift may occur and dullness to percussion over the involved side will be easily discernible. Roentgenograms will disclose cloudiness on the side of injury.

One might think of hemothorax as being slow or rapid in progression. The latter is an acute emergency. Hemothorax should be treated promptly, for, contrary to popular conception, blood in the pleural cavity often clots early.³

Among the sequelae of hemothorax are empyema, reduced pulmonary function, late pulmonary suppuration, and body deformity. If the blood in the pleural cavity is not removed, the lung becomes imprisoned by a rind and the lung is limited in breathing. Since it takes less oxygen the pulmonary artery sends less blood through it attempting to prevent hypoxia. The condition tends to become progressive² (Forsee).

If the bleeding is slow, a large bore needle (No. 14 to 16) attached to a large syringe equipped with a three-way stop-cock is the simplest method of removing blood from the pleural cavity. Generally a puncture through the 5th interspace in the midaxillary line is a good spot. A common error is to insert the needle too low and to obtain a "dry tap" because the tip of the needle impinges on the diaphragm. Once the blood has been located, a hemostat ought to be applied to the needle to prevent it moving further into the chest. If the blood continues to be removed in large quantity and the cloudiness seems not to decrease, one is undoubtedly dealing with continuing intra-thoracic hemorrhage and early thoracotomy will be necessary.

The bleeding may be from an intercostal artery, from the internal mammary, or from more major vessels. Exposure and ligation of the bleeding points is necessary. If a major pulmonary vessel is injured resection of the portion of the lung supplied by this vessel is necessary. Injuries to the great vessels are often fatal before anything can be done.

If the blood is clotted, streptokinase and streptodornase are instilled into the pleural cavity

and then in a few hours aspiration is tried. It seems to be the experience of many that these enzymes are often ineffective in making clots liquid and thus amenable to aspiration. There is an inherent danger in the use of these enzymes and their popularity seems to be waning.

We have been employing early thoracotomy with evacuation of clots and fluid if there is over $\frac{1}{3}$ of the lung encased by hemothorax. We have not found it necessary to wait 2-3 weeks for the blood to be organized after clotting. It has been easy to remove clots in the first week after the accident thus restoring the chest to near normal immediately. An intercostal drain with negative suction is left in place for about 48 hours. In general, results have been most satisfactory when we have employed this mode of therapy.

Pneumothorax

Pneumothorax may occur from injury to the pleural surface by a jagged rib, by rupture of an emphysematous bleb, or may be due to a sucking wound of the chest. Often a fractured rib will "stab" the lung and cause a leak from the tracheo-bronchial tree through the visceral pleura. Diagnosis is readily made by a roentgenogram observing the collapsed lung centrally and the absence of pulmonary markings in the remainder of the chest on the side of the injury. Mediastinal shift is usually slight. After a few hours, the rent in the visceral pleura will seal itself and aspiration of the air from the pleural cavity will restore normal pulmonary physiology. If a sucking wound is present the opening in the chest wall must be closed and then aspiration of air from the pleural cavity carried out.

Tension Pneumothorax

Should there be a rent in the visceral pleura or a sucking wound with a "ball-valve" action, the pleural cavity on the side affected will be "pumped full" of air thus displacing the heart and great vessels to the opposite side with compression of the remaining lung. This may develop rapidly after injury resulting in cyanosis, severe shock, and distention of peripheral veins. Respirations will be very ineffective. Diagnosis is made by the history and the findings of pneumothorax with mediastinal shift. Confirmation may be obtained by roentgenograms. This is an extreme emer-

gency and one must not wait for roentgenological proof. The air must be released by inserting a needle into the pleural cavity on the affected side. Following this, the chest is treated as any other pneumothorax.

If pneumothorax persists or is recurrent because the broncho-pleural connection will not seal, thoracotomy becomes necessary. A few interrupted sutures over the rent in the lung have successfully closed the communication and a re-expansion of the lung is then feasible.

Bronchial Rupture

Bronchial rupture occurs most often after a crushing injury and should be kept in mind in cases in which, after a pneumothorax has been relieved, a portion of the lung does not re-expand. If tension pneumothorax and mediastinal emphysema develop after a non-penetrating injury to the chest, a bronchial rupture is a possibility. Bronchoscopy will prove the diagnosis. Primary suture with preservation of pulmonary tissue should be done if possible before stricture and suppuration occur. If suppuration occurs, resection will probably become necessary.⁵

Hemo-pneumothorax

The presence of fluid and air in the pleural cavity in combination is seen more often than either alone. The pneumothorax must be treated according to the methods outlined above, and the blood must be removed.

Esophageal Perforation

Esophageal perforation usually occurs from trauma to the esophagus by the endoscopist or from swallowing foreign bodies. Occasionally a bullet will penetrate the esophagus and miss the great vessels thus permitting the patient to survive. As a rule he notes dysphagia and pain may radiate into the epigastrium. Temperature elevation is seen early. Empyema will develop with the onset of mediastinitis. Immediate drainage has been the time-honored procedure, employing Penrose drains. Constant suction on a small catheter inserted into the region of the fistula will promote healing. Recently Dr. Weis- sel has presented a series of cases of esophageal perforation treated with primary suture and his results are commendable.

Cardiac Bruise

Cardiac bruise is being seen with increasing frequency and most often follows an auto accident in which the driver's chest is thrown against the steering column. Symptoms are similar to those seen in acute myocardial infarction and an E.C.G. may show infarction as seen in coronary arteriosclerosis. One ought to be particularly suspicious of this complication in any person severely injured who develops evidence of circulatory insufficiency, venous distention, or symptoms of myocardial infarction.

Penetrating Wounds

Sucking wounds of the chest are produced by injuries large enough to cause an opening in the chest which does not seal itself off by edema and tissue swelling. Generally speaking, the larger the hole, the more severe are the symptoms. As a result of the communication between the outside and the pleural cavity, respiration becomes inefficient. On inspiration, air is sucked into the cavity instead of down the trachea and paradoxical respiration ensues. If the hole is larger than the diameter of the trachea, symptoms are likely to be unusually severe. Immediate treatment should consist of sealing off the hole with tightly packed vaseline gauze. This then ought to be followed by treatment of the accompanying pneumothorax as outlined above.

Heart Wounds

Heart wounds are serious because of the production of cardiac tamponade. The latter is manifested by rapid, weak pulse, low blood pressure, weak to inaudible heart sounds, distended veins, and a distended pericardium on roentgenological examination. Elkin feels that most will respond to simple aspiration of the pericardial sac, and only if bleeding continues will it be necessary to resort to thoracotomy and suture of the organ.

Blast Injuries

Blast injuries are sustained infrequently in civilian life in the United States but are familiar to those in the military service and in the bombed cities of the last war.

Zuckerman⁶ concluded that pulmonary lesions seen in blast injuries were the direct result of

the pressure component of the blast with the body.

Symptoms may be delayed several days but consist of shortness of breath, cough with blood tinged sputum, and tachycardia, basal rales, and increased density of the lungs on roentgen examination.

Presumably there is alveolar and capillary rupture with bleeding into the lung parenchyma.

Treatment should consist of bed rest, sedation, limitation of fluids, anti-biotics, and oxygen therapy.

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To Continue the Fight

It has been announced that the American Heart Association's goal for the nation during the February campaign is Ten Million Dollars. Indiana's fair share of this sum is Two Hundred Thousand Dollars.

THE CAROTID SINUS REFLEX

III. Spontaneous and Induced Stokes-Adams Attacks In a Patient with the Hyperactive Reflex

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Mentone

and

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Kewanna

THE ATTACKS of unconsciousness, muscular twitchings and generalized convulsions which were first described by Morgagni¹, Adams², and Stokes³, have until recent years been considered to be due always to ventricular asystole resulting from heart block. However, in 1941, Parkinson, Papp, and Evans⁴ found only 55 percent of reviewed cases demonstrated this electrocardiographic abnormality, the remainder being due to ventricular tachycardia, ventricular fibrillation, or combinations of these with ventricular asystole. Schnur⁵, Scott and Sanceta,⁶ and others have substantiated this observation.

The exact mechanism involved in the production of these ventricular arrhythmias which result in convulsions and unconsciousness has not been clearly demonstrated. Charcot⁷ first suggested that the vagus was responsible, and that the mechanism was entirely reflex. However, the association of organic cardiac disease and structural abnormalities of the cardiac conduction system with these attacks pointed to local lesions as causative. It now appears that the attacks are usually produced by a combination of these factors: that the reflex influences act as the trigger mechanism on a heart already damaged by abnormalities in coronary circulation. There are obvious exceptions to this, such as attacks of purely reflex origin originating from intracranial pathology.^{8a, b, c, d, e} Likewise, as will be discussed later, the hyperactive carotid sinus reflex can induce attacks of unconsciousness in patients who demonstrate no evidence of cardiac pathology. Certainly it would appear that a hyperactive reflex system of some type is essential to the production of these attacks in many

patients,^{6, 9, 10} while in others the initiating factor may be localized myocardial ischemia alone.⁵

The role of the carotid sinus reflex in the production of attacks of syncope, with or without convulsions, was first clearly demonstrated in the work of Weiss and Baker⁹. The action of the carotid sinus mechanism in slowing the heart and lowering blood pressure had been discussed by numerous preceding authors (dating from Parry in 1799, as cited by Weiss and Baker), but they were the first to investigate the problem exhaustively from a clinical point of view. Their differentiation of the actions of the reflex mechanism into vagal (slowing of the heart), vaso-depressor (lowered blood pressure), and cerebral (weakness, vertigo, syncope, etc., without effect on pulse rate or blood pressure), has been repeatedly substantiated and need not be repeated here.

Since 1933, the literature contains many papers on the so-called "Carotid Sinus Syndrome", produced by the hyperactive carotid sinus reflex^{11, 12, 13, 14, 15, and others}. The nervous pathways have been defined and the clinical manifestations discussed in detail. However, the inter-relationship of the Stokes-Adams attack and the carotid sinus syndrome has often been neglected in these discussions. Almost all of the illustrative electrocardiograms show that the efferent reflex limb ends in the SA node, with the production of sinus arrest and resultant ventricular asystole. (Except in hyperactivity of the carotid sinus reflex, sinus arrest is an extremely rare clinical cause of syncope and convulsions). Although Weiss and Baker⁹ had noted the frequent occurrence of partial or complete AV block in their patients, this has been

relatively uncommon in the authors' experience, as well as in the published series. Ferris *et al*¹¹ noted a predominance of effect upon the SA node, and also observed that there was no ipsolateral or contralateral relationship between the stimulated side and involvement of the SA or AV node.

Certain clinical features are of interest. The "Carotid Sinus Syndrome" is most common with advancing years and in the presence of hypertension and/or arteriosclerosis. In such patients there is also apt to be coronary disease with varying degrees of myocardial ischemia. These patients, then, are those who are also most likely to have Stokes-Adams attacks. It does not appear to have been emphasized sufficiently that the hyperactive carotid sinus reflex may be a common cause of attacks of unconsciousness in elderly people. Inasmuch as the treatment for the carotid sinus syndrome and for idiopathic Stokes-Adams seizures may be the same (especially as regards ephedrine), this differentiation may appear unimportant. However, for two reasons it is very important. The first is as regards prognosis. Prospect for an extended life span is obviously much better in a patient who has a carotid sinus syndrome than in one with advanced myocardial ischemia from coronary disease. The second reason concerns digitalis. If the attending physician incorrectly regards the attacks of weakness and faintness (often confused with breathlessness) as an indication for its use, the attacks may be made worse, as digitalis potentiates the carotid sinus mechanism.

Case Report

The following case illustrates some of the above points, and also demonstrates the combination of etiologic factors often present in these patients:

This 68 year old white male was first seen by one of the authors (K.K.K.) in November of 1946. At that time he was complaining of substernal distress on exertion, this symptom having developed rapidly within the preceding few days. The electrocardiogram revealed a complete AV block, but no changes indicative of an acute coronary episode. The complete block soon cleared, but subsequent cardiograms showed a partial AV block (PR 0.24 seconds), and a delay in QRS conduction (0.15 seconds) appar-

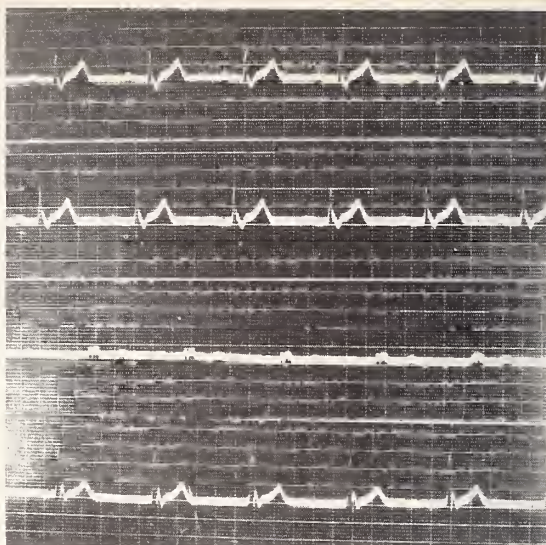


Figure 1. Cardiogram made on patient prior to onset of convulsive seizures. Note the prolonged PR and QRS intervals. (The 4th lead is CF4).

ently caused by a right bundle branch block. (Fig. 1.)

From December, 1946, to February, 1949, his course was relatively uneventful, although he had reduced exercise tolerance, complaining of some dyspnea and substernal distress. However, he continued with moderate activities and was not seriously incapacitated. It is not known whether he received digitalis during that period.

In February, 1949, he began to experience short periods of unconsciousness, associated with generalized muscular twitching. There was a slight aura, so that he was usually able to sit down or lie down if standing. The attacks were not associated with exertion, and did not appear to be affected by position. They would come on whether he was lying in bed or moving about. He had never noted that position of his head or body had any effect on them. Neither had he observed any etiologic effect of shaving or of a tight collar. There had been no constant association with meals, although he noted increased belching after attacks. (He had decided that this was important, however, and had practically stopped eating because he thought foods induced the seizures.)

The periods of unconsciousness were always brief (30-60 seconds), but as they became more frequent he was increasingly incapacitated. Eventually the seizures were coming every 15 to 30 minutes, and he was completely bedridden.

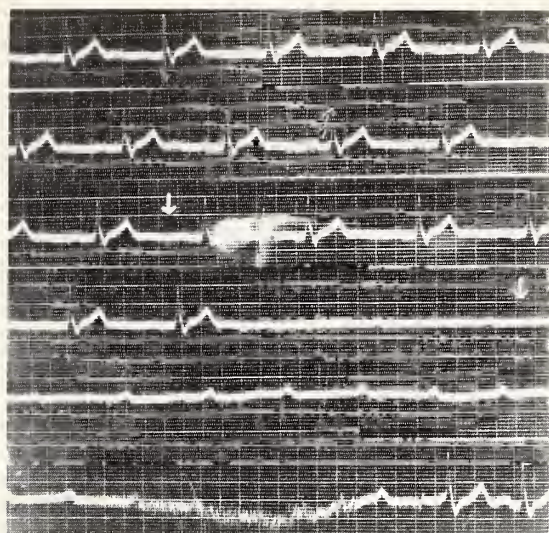


Figure 2. A continuous strip of lead 2 recorded during a period of ventricular asystole induced by carotid sinus pressure (duration of pressure indicated by the arrows.)

When first seen (by D.L.U.) in April, 1949, the patient was lying quietly on an examining table. At intervals of 15 to 20 minutes he would suddenly become unconscious, and develop mild generalized clonic convulsions. The attacks would last 30-60 seconds, and were not accompanied by incontinence, tongue biting, or nausea. He would return to complete consciousness slowly, with some belching, but without headache or painful sensations of any type.

During each attack he was pulseless, and no apical impulse could be heard for 10 to 20 seconds at the beginning of an attack. Then the heart rate would resume a normal rhythm with little evidence of entry extrasystoles. Between attacks his blood pressure was in a low normal range, dropping to undetectable levels during the seizures.

Pressure on the right carotid sinus would immediately reproduce an attack, similar in all respects to the spontaneous ones. This was done repeatedly, and at varying time intervals, in order to be certain we were not merely coinciding with the onset of the "natural" seizures. The amount of pressure on the right necessary to produce an attack was very slight, but on the left no response was obtained, even with heavy pressure.

The electrocardiographic studies were incomplete because of mechanical difficulties with the equipment, but we were able to demonstrate one

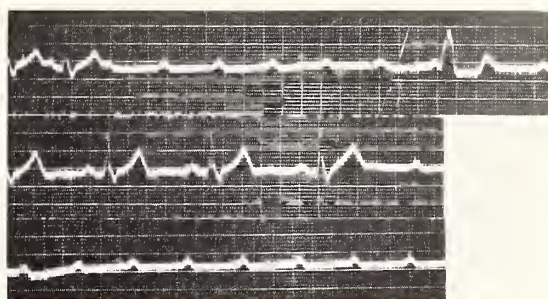


Figure 3. A continuous strip of lead 2 recorded during a spontaneous seizure.

complete sequence of an induced attack by carotid sinus pressure: the appearance of total AV block with ventricular asystole, unconsciousness, convulsion, return to normal rhythm and to consciousness (Fig. 2). Later we obtained a short sequence in a spontaneous attack, with complete AV block, temporary restoration of normal rhythm, return to block, and eventual recovery which isn't apparent in Fig. 3, because the equipment failed to recover although the patient did. A typical convulsion occurred during the period of ventricular asystole. It is to be noted that the auricular rate, and the appearance of the P wave, is somewhat different in this spontaneous attack as compared to the induced one.

The patient was immediately placed on ephedrine and phenobarbital, and has remained in fair health since that time. It has been necessary to give him a rather large amount of ephedrine or ephedrine-like compounds, but so long as he takes these regularly he has no seizures, and has been active in his business.

Comment and Conclusions

Although this 68 year old man had a past history of cardiac disease, and had a cardiogram showing definite myocardial damage, it would appear that his Stokes-Adams attacks were of reflex origin from a hyperactive carotid sinus reflex. Therapy directed toward abolishment of the cardio-inhibitory efferent limb of the pathologic reflex was completely successful and has remained so.

Cardiograms in spontaneous and induced attacks were essentially similar, the only notable difference being in the character and frequency of auricular impulses as manifested in the P waves. During the induced attack the auricular contractions were less frequent (vagus effect on the SA node) and lower in amplitude. In both

the spontaneous and induced attacks the mechanism producing ventricular asystole was complete AV block.

The prognostic implications of the differential diagnosis in this patient appear obvious.

Schwartz and Eichna¹⁶ have recently reported a similar case, in whom spontaneous and induced convulsions were caused by total AV block. In their patient, however, the basic rhythm was frequently abnormal, with varying degrees of AV block, and eventually the patient stabilized in complete block. After this development it was not possible to induce attacks by carotid sinus pressure, and spontaneous seizures no longer occurred. In view of the evidence of local pathologic changes in the cardiac conduction system (manifested by the varying degrees of AV block) it was their impression that the spontaneous attacks resulted from local changes rather than from a hypersensitive reflex system. In our case, in contrast, it has appeared that the abnormal carotid sinus reflex was the primary etiologic factor, with local changes secondary.

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Red Cross Highway First Aid Stations

More than 66,000 persons were given first aid by operators of 2,165 Red Cross highway first aid stations, 13,100 mobile first aid units, and by first aiders who manned stations at fairs, parades, and other public gatherings.

RABIES, A THREAT TO HUMAN HEALTH

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THE SERIOUSNESS of rabies as it may affect human beings does not lie so much in the number of persons who may contract it, for the total is certain to be relatively small. Moreover, the proportion that develops the disease after having been bitten by proven rabid animals has frequently been found to be much less than 50 percent. The gravity of the disease lies in the fact that, once it develops, the stricken individual is doomed, and in the fact that the disease is preventable and deaths need not occur.¹

There is no other disease about which the public is more misinformed. The fears, horrors and superstitions of exposed individuals, magnified by a superabundance of bad advice from well meaning friends, often produce a state of mental panic before the physician can be reached. Circumstances of exposure so infinitely remote as to make the possibilities of infection ridiculous and unworthy of even momentary consideration often cause extreme mental anguish. Undue apprehension is probably as common a symptom among the many recently exposed persons as it is among the very few who develop the disease clinically. Under such circumstances, the individual is often unable or unwilling to accept medical advice and insists on vaccine treatment, while the physician, too, often fails to maintain professional equilibrium and allows himself to be influenced by the undue apprehension of the patient.²

It is not hydrophobia but rather "rabiphobia" which constitutes the major and troublesome problem to the practicing physician and health officer. The administration of antirabic vaccine to persons actually bitten or scratched by the teeth of known or suspected rabid animals is a relatively simple and justifiable procedure regardless of the outcome, in that the danger of the disease is far greater and more serious than any ill effects from the vaccine. But for exposures other than actual bites, the danger of

treatment complications far exceeds that of either rabies or "rabiphobia."³

Realizing, therefore, that education is one of the fundamentals of clarifying the rabies picture with regard to human health, my discussion will include: (1) an historical summary of the disease; (2) a brief description of the disease in man; (3) the handling of the suspected source of contact; (4) first aid treatment on the spot and local treatment by the physician; and (5) the indications for prophylactic vaccination.

Rabies is an acute specific infection of the nervous system caused by a filterable virus. The disease is customarily propagated in dogs and related animals, such as the wolf, fox, coyote and jackal. Man and all warm blooded animals are susceptible to the disease. The virus is often present in the saliva of rabid animals, and the usual mode of transmission is by means of a bite and the contamination of resulting wounds with infected saliva.⁴

It is convenient to divide the history of rabies into four periods, the first period going back to ancient times. Akteon, son of Aristeus, died of rabies about thirteen centuries B. C. The disease was well known in Aristotle's time from 384 to 322 B. C. and at the time of Celsus, in the first century A. D. From this time until 1800, little was added to the knowledge of rabies.

The second period began in 1804, when Zinke transferred rabies from an infected animal to another animal, by painting the saliva of a rabid dog onto the fresh wound on another dog, the second dog developing rabies. He also transmitted the infection to a rabbit and to a chicken in the same way. The method of transmitting rabies from dogs to rabbits was developed and in 1879 Galtier showed that this was a good method of determining whether a dog had rabies, and Raynaud showed that the rabies virus could be transmitted from man to rabbits. In 1826 von Krugenstein expressed the opinion that the rabies virus was in the central nervous system, and

Duboue in 1881 confirmed this finding and considered that the virus reached the central nervous system by way of the nerves.

The work of Pasteur and his coworkers marks the third period in the study of rabies. Pasteur began his work in 1880 and announced his results at the International Medical Congress in Copenhagen in 1884. Pasteur showed that the rabies virus is constantly in the central nervous system of rabid animals, and that subdural injection of small amounts of the brain or spinal cord of rabid animals into susceptible animals constantly produced rabies. He showed that when the rabies virus from dogs is injected into rabbits, after a few passages, the virulence of the virus for the rabbit is increased, until it kills in a short time. This virus no longer produced rabies in dogs, but rendered them immune to a subsequent injection of virus from a dog. He applied this method to the immunization of persons bitten by rabid animals—with the results we know today.

The fourth period in the history of rabies began in 1903 with Negri's discovery of the small bodies in the ganglion cells in the central nervous system of rabid animals. The regularity with which these bodies are found in the brain of rabid animals makes it possible to make the diagnosis in 90 percent of the animals that die of rabies without having to wait for the disease to develop in inoculated animals.⁵

In *man* the disease is frequently ushered in with a short prodromal period of mental depression, a feeling of impending danger, insomnia and nightmares. Ungovernable restlessness seizes the patient. Melancholia with delusions of persecution is common. Hyperesthesias of the skin to changes of temperature and especially to currents of air, and increased sensitiveness to sound and light mark the steady progress of cerebral irritation. A patient, conscious of the real situation, weighed down with terror, often becomes manic; the restlessness increases to uncontrollable agitation. He jumps out of bed, rushes around the room, screams, strikes his head and fists against the walls, climbs upon the furniture, tears his clothing. An excessive flow of thick tenaceous saliva pours over the face and neck and becomes smeared on his hands and clothes and over the bedding and floor. This so-called "frothing at the mouth" is present as soon as

the throat spasms become severe enough to prevent swallowing, and evidently is due to the inability to take care of normal saliva. The excess saliva, incorporated with the air and secreted on account of the constant movement of the muscles of the neck and jaw, causes the frothing to occur. Periods of rage are followed by moments of calm in which the patient usually shows anxiety for the safety of those around him and warns them of the approach of another crisis. Convulsions are brought on by the least irritation of the skin and by the slightest current of air. Aerophobia is, in fact, one of the most characteristic symptoms of rabies. Blowing the breath on the neck of the patient often precipitates convulsions, and is valuable in differentiating the disease from hysteria. The slightest breeze brings on respiratory difficulties which threaten death from suffocation; the breath comes in spasms, dyspnea is extreme, and there are epileptiform seizures or tetanic rigidity.

The characteristic symptom which gives to the disease its common name, *hydrophobia*, appears as a rule 24 or 48 hours after onset. It is rarely absent. This symptom, due to the reflex irritability of the center of swallowing, gives rise to those laryngeal spasms so agonizing to the patient and so distressing to the attendants as to justify the universal dread of the disease. When the victim lifts the glass to his lips there is an immediate viselike contraction of the muscles of swallowing with an excruciatingly painful spasm of the glottis and pharynx. The entire body trembles with convulsive movements; the jaws are clenched, respiration is impossible. The patient feels that he is being strangled to death, and, in fact, not infrequently dies suddenly during the spasms. After several attempts to drink, the pain is so terrible that despite the intense thirst the patient cannot be induced to try to swallow liquids, and the mere sight of water or mention of the word brings on an attack. Death may occur during a convulsion, but as a rule, after two or three days of suffering, exhaustion or paralysis leads to death from cardiac or respiratory failure.⁶

This disease can be prevented, but the responsibility of its prevention and control rests as much with the dog owners and the exposed as with the veterinarian, the health officer or the doctor. The public **MUST** comply with the following procedures to assure the proper manage-

ment of the danger which arises from this disease:

First, wounds inflicted by animal bites should be washed immediately with soap and running water.

Second, immediately after the first cleansing, all wounds of this type should be dressed by a physician and his advice as to the indications or contra-indications for anti-rabies vaccine treatment followed closely.

Third, any dog that has bitten a person should be confined for a period of 14 days. If the animal has rabies, it will usually die in a few days, and will assuredly succumb within a two week period. If rabies is present in the community, a veterinarian should be consulted as to whether the biting dog has symptoms of rabies. This is important because as long as the dog fails to show symptoms of the disease or does not die it is unnecessary to begin vaccine treatments. Such procedures will save many unnecessary treatments. It is advisable to have biting dogs under observation in a proper kennel, such as that of the veterinarian, the Humane Society, or a dog pound. Dog owners are apt to be negligent and allow the biting dog to stray away. If the biting dog is a stray and has escaped apprehension, local authorities should be notified, so that the dog can be caught and held for observation.⁴

Fourth, do not kill the animal. When it is necessary to kill an animal **do not** shoot it through the brain.

Fifth, animals unavoidably killed or found dead should have the head removed immediately and shipped in a water tight container packed in ice via EXPRESS to the laboratory of the Indiana State Board of Health for diagnosis.

The part your physician plays in the management of the rabies problem is threefold: (1) local treatment of the exposed area; (2) decision as to whether or not to administer rabies vaccination; and (3) administration of the vaccine when indicated.

Complete reliance in the effectiveness of anti-rabies vaccine is never justified, and cauterization of the wound made by the animal with strong nitric acid is necessary for adequate protection of the patient. There is no substitute

for nitric acid; mercurochrome and agents which coagulate tissues are worthless. If areas of heavy nerve distribution are involved, the use of nitric acid is all the more imperative.² In cases of severe laceration of the face, which is most apt to be followed by infection, this method has been found to be impractical.

Most, if not all, the situations of human exposure can be safely disposed of to the best interests of all concerned if the medical advisor, either practicing physician or health officer, will apply, in principle, the following course of procedure, outlined by T. F. Sellers.³ These procedures are closely followed by the Indiana State Board of Health.

The first step is to consider the HISTORY of the offending animal. If the evidence falls within the following categories, then the animal should be considered as potentially infectious:

1. The animal is clinically rabid, even though the post-mortem brain examination fails to reveal Negri bodies.
2. The brain of the animal shows typical Negri bodies, even though the clinical behavior of the animal before death was not suggestive of rabies.
3. The animal disappears after biting, or cannot be definitely identified.
4. Any animal that bites without provocation and is immediately killed should be regarded as suspicious even though the laboratory findings are negative.

Having thus arrived at the conclusions that the animal in question is rabid or that rabies cannot be ruled out, the next step is to direct attention to the nature of the exposure and the need for antirabic treatment. Such treatment is indicated:

1. When there are visible wounds into or through the bare skin that were known or suspected to have been made by the teeth or claws of the animal.
2. When the wounds were inflicted through clothing which was torn by the teeth of the animal.
3. When there is reason to suspect that the wet saliva came in direct contact with fresh, open or raw pre-existent abrasions.

4. When the person exposed is a small child who has been in direct contact with the animals but who is too young to give reliable testimony.

Anti rabic treatment is contraindicated:

1. When the exposure is limited to contact of the saliva with the unbroken skin anywhere on the body, including the face or mouth.

2. If the saliva came in contact with pre-existent wounds which are known to be more than 24 hours old or which are covered with an unbroken scab.

3. If the teeth wounds are made through clothing which is not torn. Such wounds are usually bruises or due to friction from the cloth.

4. If the exposure is limited to:

a. Handling or petting the animal or of other animals with which the infected animal has been fighting.

b. Handling of objects contaminated with saliva.

c. Drinking the milk of rabid cows or goats.

5. If the bites or scratches were inflicted not less than seven days prior to the detection of visible signs of the disease.

6. If the biting animal remains normal for as long as one week after biting.

Before administering treatment, the medical advisor should never fail to question as to previous treatment. Regardless of the elapsing interval since the last treatment, re-immunization should be avoided for borderline exposures, such as superficial wounds of the extremities. Re-treatment should be limited in any case to a short booster series of five or six injections.

In summary I wish to emphasize these facts:

1. The mortality rate in human rabies is 100 percent.

2. Human rabies can be successfully prevented provided there is complete cooperation between the dog owner or the exposed, the veterinarian and the local health officer or the practicing physician.

3. The successful management of the exposure depends upon a sensible, critical and careful analysis of the conditions surrounding the exposure.

4. The judgment of the physician as to whether or not to administer rabies vaccination must be relied upon.

5. Antirabic vaccine is not harmless and has caused more deaths than have rabies when given to persons only indirectly or remotely exposed.

6. There have been no reported deaths from hysteria or rabiphobia.

7. The only positive way to stamp out human rabies and the fear associated with the knowledge of its presence is to wipe out rabies in animals. It can be done. It has been done in England—twice.

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PUBLIC LAW 779

THE "Doctor Draft Law" will expire next July 1. Between now and then the problem of providing the armed services with doctors after July 1 by some fair and equitable scheme must be solved. At present it would appear that a revision of the present law would be the best solution.

The A.M.A. through its Council on National Emergency Medical Service has launched a study of the situation, in cooperation with the military services. While experience with Public Law 779 has provided considerable background for opinions and recommendations, there are still several variables which require further study.

These variables are:

1. Revisions in military medical requirements.
2. Effectiveness of medical procurement by voluntary methods.
3. Efficiency of utilization of military medical personnel.

4. The extent to which military medical service is extended to military dependents.

The A.M.A. House of Delegates at the Denver session adopted a five-point program calling for revision of physical requirements, better recruitment methods, greater use of civilian doctors for dependents, more efficient use of all government doctors and an equitable point system for calling-up physicians.

Revised physical standards have now been adopted. It is estimated that approximately 4,000 physicians in Priorities I, II and III, previously rejected, will be re-examined. Several pilot studies and research projects are to be conducted by the armed services in the next few months in order to accumulate further information on the entire problem.

It is probable that the new bill when it is drafted will call for a simplified classification—veterans and non-veterans. It also probably will

direct the induction of special registrants now classified in Priorities I and II when they become available for duty.

In this connection recent graduates are reminded that special registration under Public Law 779 is mandatory within five days after

receiving the M.D. degree, whether the person in question is registered under the regular draft law or not. The only exceptions are those persons who hold reserve commissions in the armed forces, and for this purpose the Public Health Service is not now considered an armed service.

CARDIAC CLINIC CEREMONY FEBRUARY 9

IN A DEDICATORY ceremony on Monday, February 9, Indianapolis General Hospital's cardiac clinic will be named the ROBERT M. MOORE HEART CLINIC, as a memorial to the noted Indianapolis heart specialist who died on June 23, 1952.

The dedication will occur in General Hospital auditorium at 4:00 o'clock P.M. Dr. Harry Plummer Ross, Richmond, Indiana, Heart Foundation president, will preside. Mrs. Moore will be the honored guest.

The Heart Foundation will present a bronze plaque to the hospital in honor of the late Doctor Moore who was primarily responsible for the clinic's inception nearly 30 years ago.

Dr. Cyrus J. Clark, board member, will make the presentation for the Heart Foundation. Dr. Gerald F. Kempf, superintendent, will accept the plaque for the hospital.

Doctor Moore was professor of clinical cardiology at the Indiana University School of Medicine for more than 20 years. He was the

first president of the Indiana Heart Foundation (1948-49) and chairman of its board of trustees and a member of the staffs of the Indiana University hospitals, the visiting staff of St. Vincent's Hospital and of the staff and advisory board of Methodist Hospital.

Doctor Moore also was a member of the American, Indiana and Marion County Medical Associations, member and past-president of the Indianapolis Medical Society and member and councilor of the American Heart Association.

Principal address for the dedication will be given by Major General George E. Armstrong, Surgeon-General, United States Army, Washington, D. C.

General Hospital staff members and directors, Dean and faculty of Indiana University Medical School, members of the Indiana State Health Board and Indianapolis Health Department, city officials, Heart Foundation directors, other city physicians and personal friends of the late Doctor Moore will attend the dedication.

PATHOLOGY AND THE SCIENTIFIC EXHIBIT*

IT IS BELIEVED that the oldest existing pathological society in the world is the New York Pathological Society, founded in 1844. This medical organization antedates not only the New York Academy of Medicine by several

years but also the American Medical Association. The Société Anatomique was formed in Paris in 1803 but lasted only five years, although it was revived in 1826. A pathological society was formed in Philadelphia in 1839, but it, too, expired after a brief life of only four years. Except for the New York society, pathology does not appear to have been organized as a specialty until 1900, when the American Association of Pathologists and Bacteriologists was

* This editorial from one of the nation's leading medical journals should be of added interest to Indiana doctors because of the recognition given one of this state's outstanding leaders in the profession, Dr. Frank B. Wynn.

formed, to be followed by the Pathological Society of Great Britain and Ireland in 1906, the American Society of Experimental Pathology in 1913 and the American Society of Clinical Pathology in 1922.

The revival of interest in 1900 coincided with the first Scientific Exhibit of the American Medical Association, held in 1899. The lone exhibitor was a pathologist, Frank B. Wynn, of Indianapolis, who showed specimens, with proper case histories. Dr. Wynn's initiative was richly rewarded, for the Scientific Exhibit, as it is known today, is one of the outstanding features of an annual meeting of the American Medical Association, and pathology is frequently the central core around which the whole exhibition is planned.

The Wynn exhibit in 1899 was the natural sequence of his prior activities. The Indianapolis Medical Society, beginning about 1895, held a "case history" night once a month, which gradually developed into a "pathologic specimen" night. One of the leaders in this movement was Dr. Wynn, a teacher in pathology at the Medical College of Indiana (later to become Indiana University College of Medicine). During the course of several years Dr. Wynn amassed a sizeable collection of specimens. When the Indiana State Medical Society held its fiftieth anniversary in Indianapolis in 1899, Dr. Wynn, at the urging of William N. Wishard, was encouraged to arrange an exhibit of his specimens. The response was so enthusiastic that the state medical society voted to send the collection to Columbus, Ohio, for the American Medical Association meeting the following week.

Dr. Wynn was doubtful about the advisability of the venture because "nothing like it had ever been done before." However, a vacant store across from the Capitol building in Columbus was rented, shelves and benches installed, and more than 700 specimens shown. (Whether all these specimens were from Dr. Wynn's collec-

tion at the Medical School, or whether there were other contributors is not known.)

In 1900, W. W. Keen, president of the American Medical Association, appointed two "unofficial" committees—one to form a new section on pathology and the other to organize a pathology exhibit. Dr. Wynn was secretary of both groups. The exhibit was shown in the same room where the Section held its meetings.

In 1902, when Dr. Wynn was chairman of the Section on Pathology and Bacteriology, his chairman's address was devoted largely to the future of the Pathology Exhibit. Among other recommendations he suggested that the name be changed to Scientific Exhibit, the scope be broadened to include all medicine, the work be placed in entire charge of a director, and the director, in conjunction with the Section officers, correlate the work of the Scientific Exhibit with the work of the various sections.

Awards were given in the Scientific Exhibit of the American Medical Association beginning in 1908, the first gold medal going to Howard R. Ricketts for his exhibit on tick fever.¹

But the New York Pathological Society is the sturdy ancestor of much of the advance in this special field of medicine. Among the founders in 1844 were Lewis A. Sayre, Willard Parker, Monzo Clark and James R. Wood. Later came Francis Carter Wood, James Ewing, Francis Delafield, T. Mitchell Prudden and many others of national and international fame. Notes of the meetings as early as 1847 have been preserved and have recently been reproduced.²

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—*New England Journal of Medicine*



Editorial Notes

Just 10 days before his death, William D. Schwartz, M.D., Portland, was presented with a Certificate of Public Recognition, the highest award of the American Legion. The veteran Portland doctor was recognized by the Legion for his service to the community over a period of 55 years. A few close relatives and Legion officials heard the reading of the award which said in part: "This award does not delve into the many attributes with which you are so richly endowed. Nor does it enumerate the families who have been comforted and relieved of pain and suffering by your knowledge, skill and experience."

The award commended him for his selfless service during the "countless nights" when he was disturbed from his sleep to serve humanity, "giving so much cheerfully and willingly for so little in return."

"It is an acknowledgment by our organization that you have throughout your long and illustrious career displayed all of the qualities that cause you to be honored with this Certificate of Public Recognition. It is the highest honor the American Legion can bestow upon anyone. It is our humble way of acclaiming you an outstanding citizen," the award concluded.

"Dr. Charles E. Thomas Day" was celebrated on December 8 in Leesburg by more than 800 friends who attended the Leesburg Lions club public program arranged as a tribute to the home town physician who has served the community continuously for 52 years. He was the recipient of a lounge chair and footstool. Doctor Thomas is still in active practice. Although he made and retained his hundreds of patients in Kosciusko county through his general practice, in recent years the Leesburg doctor has attracted national attention as a result of his success in the treatment of arthritis.

Half the hospitals in the United States look to the Red Cross for all or part of the blood needed to treat their patients. During the fiscal year ended June 30, 1952, the Red Cross collected 1,681,500 pints of blood for civilian, military, and veteran hospitals in this country. The Red Cross and cooperating blood banks collected an additional 2,439,700 pints for shipment to Korea and for dried plasma defense reserves.

Letter to the Editor

Mza, November 19, 1952

Dear Sir:

I am a medical student interested in increasing my knowledge in the largest possible number of subjects, but unluckily I can't buy foreign publications and local libraries have not a good deal of American material. By these reasons I am addressing this letter to you, in the hope that perhaps you will be able to help me in my studies by sending me some journals, book or other kind of publication containing literature about any medical subject or specialty (preferably related to Endocrinology and Biochemistry).

Please note that I don't mind if copies to be sent are old or second-hand and that my interested is specially confined to literature written by M.D. of Indiana or published by Indiana's societies.

Thanking you,

Yours very truly,
Juan Jose Tortajada
San Martin 739
Las Heras, Mendoza
ARGENTINA

~ President's Page ~

FELLOW MEMBERS OF THE I.S.M.A.:

BEG, borrow or buy a copy of "The Atlantic", December, 1952, and study the attitude of a fellow practitioner as portrayed in his article, "The Best Medicine For The Patient". This proponent of political medicine challenges not only our medical leadership but questions our past and present motives and accomplishments from which he has benefited as only one could benefit in a society of free enterprise. He states: "It is conceivable that private health plans might enlarge and coalesce throughout the country in a manner finally to include all people not already covered by government but such a consummation would require medical statesmanship of a type not yet in sight, at least among the controlling echelons of organized medicine."

The article consists of a resume of a number of medical experiments and is encouraged by the assurance by a member of H.S.T.'s Health Commission that their studies would confirm the existence of much unmet medical need. Of course, Mr. Ewing would have contributed the same information without wasting tax dollars on a health Commission Study.

The above challenge to these physicians should purge us of complacency and urge us to stimulate what meager statesmanship he thinks we possess to heights of commendable statesmanship as we continue to fight these advocates of "pink pills" for pink people. Adequate medical care for everybody is the goal of organized medicine but the method by which we expect to attain it is being attacked even by fellow physicians who, probably because of their present connections, wish the Federal Government to enter the practice of medicine. Already the Federal Government is in the hospital business and is operating more hospitals than any other organization with great inefficiency and excessive cost.

Unless one is born "with a gold spoon in his mouth", either a socialistic or a free enterprise society will contain people with unmet needs, not just medical unmet needs. We have unmet legal and religious needs. We have unmet caloric and clothing needs. I presume, Doctor Means thinks that if we obtain assembly line medicine, all other needs will be financed by government funds. If one desires an economic and medical care paradise why not create plans for all unmet needs; medical, religious, legal, and economic, et cetera?

Doctor Means says "that a number of highly intelligent persons have swung to compulsory health insurance". Evidently they cannot foresee that Federal Medicine will raise taxes and lower the standards of medical care. Never have they suggested that lower taxes and an educational program to induce the population to be responsible "for a rainy day", whether it be due to economic reverses or health impairment, is prerequisite to a sound economy and adequate medical care. Doctor Means states: "'You are alright until you get sick,' a woman who earns her own living and supports an elderly mother, said to me recently; 'and then you're licked'." Similar conditions exist in other areas besides Boston and the medical profession is ready and willing to do its share for worthy people in cooperation with voluntary and local governmental agencies, but not under the dictatorship of the Federal Government. The majority of patients which a physician interviews could prevent being licked when ill if they had budgeted their income when well. Since the eruption of socialism in the United States for the sake of votes, people have been educated and even solicited to depend on government for medical care. And, our previous government has aided this thinking by inflation and high taxes which make medical costs in a budget look like your checking account on January 15th.

Doctor Means thinks it is significant that the 'American Public Health Association has set up a section on "Medical Care"'. Although this is a direct slap at free medical enterprise, it is not surprising because those who formulate the policies of A.P.H.S. are in favor of National Health Insurance. They have forgotten that the province of a public health department is to prevent and control disease and the province of the medical profession is to diagnose and treat disease.

And, by the way, the Chicago Tribune quoted Doctor R. J. Wilkerson, retiring president of the Southern Medical Association as follows: "General Eisenhower and other Republican leaders have given their pledge against anything socialistic, including socialized medicine, which means that the Doctors won't have to worry about political aspects in medicine and can, therefore, concentrate on taking care of sick people."

Certainly, this "Let Ike do it" comment demonstrates that we physicians are at odds over strategy which in turn plays into the hands of opponents like Doctor Means. Always, we should keep in mind that some "highly intelligent people" apparently are trying to "sotrudnichat" or "koopervat" either wittingly or unwittingly with what Lenin once said "that socialized medicine is the keystone to the arch of the socialistic state." We should remember, gratefully, that compulsory health insurance has been defeated by both Jefferson Democrats and Lincoln Republicans during the past twenty years. And, we are obligated to carry on the fight constantly within both parties, or both parties, after the political conventions of 1956, might contain in their platforms the present Democratic plank on medical care.

Paul D. Grimm M.D.

P. S. The pro's and con's of the "Federal Control of Medical Care" may seem "Dry as the remainder biscuit after a voyage", or as "Tedious as a twice told tale, vexing the ears of a drowsy man", but such let it be until we convert first, the members of our own profession, second, the public to an improved American system of practicing medicine by means of our deeds which will in the end speak louder than Cape Cod rhetoric.

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

A DOOR OPENED

Five Negro doctors have been admitted to the Charleston County Medical Association in South Carolina. This marks the first time that white and colored doctors in South Carolina have been members of the same organization.

In many ways discrimination and bigotry in the South is slowly but surely being broken down. It is well to note this for all too often examples of mistreatment of Negroes in the South are publicized while gains made by Negroes are ignored or paid little attention.

Racial prejudice is a hateful thing and it should have no place in the lives of Americans. Yet simply saying this will not erase prejudice nor will it convince people who practice it. Only a tempered, reasoned approach to the problem offers any hope of an eventual solution. Enlightened Southerners are sometimes far ahead of many in the North who advocate better treatment for Negroes.

The admission of the five colored doctors to the county medical society in South Carolina is not an event that can be compared in significance to the Emancipation Proclamation. But it is an indication of progress and as such it should be noticed and applauded. Another door that had been locked has been opened.

—Kokomo Tribune

POLITICAL MEDICINE

President Truman received the other day the report of his commission on the health needs of the nation. In praising the report, Mr. Truman sought to beat his critics to the punch in appraisal of its recommendations.

"It would be most unfortunate," he said, "if the same emotionalism which has prevented open minded study of major health proposals advanced during the last few years were to hinder the proper evaluation which this report merits."

If the critics can display more emotionalism than the drafters of the report, they will set some new high records for tizzies. The United States already has the best trained physicians, the best hospitals, medical schools, and research centers, and the highest standards of medical care to be found anywhere in the world. This care is available to the very poor as charity. The financing of its heavier burdens by self-supporting citizens is

lightened by voluntary pre-payment plans—as the report notes.

To appraise this system of medical care and reach the conclusion that it calls for improvements which can only be achieved by federal intervention and the spending of taxpayers' billions is no exercise in logic. It calls for some pretty fancy emotionalism and the commission came thru.

Consider these excerpts from the commission's opening statement of principles:

"Access to the means for the attainment and the preservation of health is a basic human right. . . . Comprehensive health service is the concern of society. . . . Responsibility for health is a joint one, with the individual citizen and local, state, and federal governments each having major contributions to make toward its fuller realization."

Health as a "basic human right" is U. N. jargon intended to obscure the individual's right to spend his earnings as he sees best. State, local, and federal governments can make what are called their contributions to better health facilities only by spending taxes for such purposes. Their "contributions" are taken away from one citizen for the benefit of another. If some citizens, thru federal assistance, are going to have better medical care, that merely means that some other citizens are going to have to pay more taxes and will, therefore, have less to spend in the future than they are now spending for medical care.

In the background of the current report is the fact that Mr. Truman and Oscar Ewing, his federal security administrator, got exactly nowhere with their proposal of state medicine, which they presented in the guise of "compulsory health insurance." The present report urges instead that existing voluntary health insurance, or as the report styles them, pre-payment plans, be expanded, but . . .

The "but" is a big one. Some people cannot afford to pay the premiums of voluntary insurance of surgical and hospital care. Two proposals are made for taking care of them. One is that the federal government match state expenditures, dollar for dollar, in paying health insurance premiums for people receiving public assistance. The other is that federal social security funds be used to provide insurance for those receiving old age and survivors' insurance [popularly called "social security"] benefits.

Local governments thruout the country already provide free medical care for citizens unable to pay for it. The citizen who can pay part of the

cost of his care, but not the full amount, can also get treatment in a public hospital, paying what he is able. The commission's proposal would merely duplicate an existing service. It would transfer part of the cost to the federal government, which means only that the solvent citizen would pay a slightly smaller local tax, perhaps, but would surely have his federal income tax boosted.

The social security reserve funds already have an actuarial deficit. They pay current benefits, but they are not accumulating sufficient funds to pay the benefits due present contributors when they stop working. Putting an additional burden on them, in the form of medical insurance given whether a retired person needs it or not, would only increase the deficit and speed the day when social security taxes, borne equally by worker and employer, will have to be increased.

The Truman-Ewing state medicine scheme was also to have been financed by an increase in social security taxes. These two proposals of public aid thru voluntary health insurance plans—which, of course, the federal bureaucracy would want to supervise as soon as they started paying money into them—are just a means of putting the foot of state medicine in the back door.

It is significant that state medicine in Great Britain, where Ewing got the ideas for his scheme, started in this very manner. Originally the government supplied "free" medical service to persons with incomes below a certain figure. Eventually the socialists forced everyone into the system. They got free medical care, of a sort, but they paid for it in their tax bills and they got such medical care, on such terms, as the politicians dictated.

Mr. Truman had to drop his original state medicine scheme because the people of the United States didn't want a gang of politicians acting as brokers between themselves and their doctors and hospitals. The current report is simply an attempt to revive this scheme on the Fabian basis.

—Chicago Tribune.

CALIFORNIA DOCTORS PONDER A NEW POSTED PRICE SYSTEM

Rather than setting fees on the traditional basis of ability to pay, a plan now under consideration would have each doctor establish a fee list from which he would not vary—except by prior agreement with the patient. In each county an overall list, showing the average of posted fees for each type of service, would be available to give patients a yardstick of medical costs.

Back of the proposal, to be voted on next spring by the house of delegates of the California Medical Association, is the feeling that both the rich and the poor are getting fewer. Corporate

sick benefits and health insurance policies bolster ability to pay.

Under the fixed-fee scheme, policyholders could be shown precisely what part of their costs would be covered by insurance.

—Wall Street Journal

TAKE OFF THE MASK, DOCTOR!

It is encouraging to see in recent news items evidence that the curtain of ancient mysticism which has surrounded the medical profession from the days of Hippocrates is slowly disappearing so that humanity may more clearly view the great works of these good men. Their efforts have been hidden too long by stupid "rules of professional ethics" which obscure truth and deny credit where it's due.

We are currently heartened by publicity of the recent Chicago operation in which Siamese twins were separated at the skull by most complicated and delicate neurological surgery.

Dispatches from expert reporters at the scene brought the public closer to the operating table than it has heretofore been privileged. Human enlightenment and increased trust of the profession stand as a valuable consequence.

Aside from the astounding skill displayed in the operation, the public was encouraged by the revelation that for this surgical triumph—one of the greatest in University of Illinois history—a million dollars worth of medical talent was mobilized.

Yet it was all given free to this family!

The general public is not aware that the medical profession, under a system of free enterprise, has always provided such free service. Were the facts known, the great Medical Center of Indiana University would reveal cases which—though possibly not identical—would be none-the-less spectacular from the standpoint of expense, facility and proficiency, all provided free.

General hospitals in every part of the nation—including the one in this city—are at this hour ministering to charity patients whose bodies will be made whole or whose lives will be saved through medical arts and sciences, the value of which is inestimable.

Sensible relations between the medical fraternity and the public demands this information be made available, especially in these days when we hear a louder clamor for socialized medicine.

We hope that freedom allowed in reporting recent medical accomplishments—including the Chicago operation—presages a time when the profession will have removed all its silly rules barring publicity so that its members may take their rightful place in the annals of a nation made great by a democratic system of free enterprise.

—Indianapolis Star.

PHYSICIANS GROUP, CAMPAIGN PLANNED BY BLUE CROSS-BLUE SHIELD

"THE DOCTORS' PLAN" to provide prepaid health care through the Blue Cross-Blue Shield Plan will be made fully available to all Indiana physicians, their families and office employees for the first time during February.

Simultaneously, during the first two weeks of the month, an intensive advertising, educational and enrollment campaign will be undertaken in 30 counties of central Indiana which will mean the addition of thousands of members in the voluntary Blue Cross-Blue Shield plan.

Although many Indiana physicians have been enrolled in the past through their county medical societies, hospital staffs, clinics or industrial connections, the February campaign period

marks the formation of a statewide medical group for the doctors, their families and all office employees. Every physician in the state will be contacted by mail.

The general campaign for new members in central Indiana will utilize television, radio and newspapers as mediums to reach the public with an educational campaign stressing the value of adequate pre-payment health care through the hospital and doctor-sponsored Blue Cross-Blue Shield.

Almost one million Hoosiers are now members of the twin plan and the February campaign is expected to carry the total well beyond the one million mark.

Lasker Awards Go to Six Health Pioneers

Six men, distinguished for medical research and public health achievement, received the 1952 Lasker Awards of the American Public Health Association at the 80th annual meeting held recently in Cleveland.

A special award went to 75-year-old Dr. Charles Edward Amory Winslow, Yale University emeritus professor of public health "for more than half a century, an inspiring and inspired leader, teacher, and exponent of public health for the nation and the world."

Others to receive the Lasker awards were Dr. Howard A. Rusk, director of the Institute of Physical Medicine and Rehabilitation of New York University's Bellevue Medical Center, New York; Dr. Brock Chisholm, Toronto, Canada, director-general of the World Health Organization; Dr. Conrad A. Elvehjem, chairman of the biochemistry department, University of Wisconsin; Sir Macfarlane Burnet, M.D., Melbourne, Australia; and two representatives of the dental profession, Dr. Frederick S. McKay, Colorado, and Dr. H. Trendley Dean, director of the National Institute of Dental Research, Washington, D. C.

The awards include monetary prizes of \$1,000, leatherbound citations reciting their accomplishments, and gold statuettes of the Winged Victory of Samothrace. The special award is \$2,500.

SYMPOSIUM ON MALIGNANCY SCHEDULED FOR MARCH 4

EIGHT of the country's leading authorities on cervical cancer will appear on the sixth annual Symposium on Malignancy, being presented Wednesday, March 4, at the Indiana University Medical Center and open to all physicians of the state.

The discussions this year will deal with one of the common types of cancer in women but one for which there is every indication of permanent relief when detected and properly managed in the early stage. It is reported that cervical cancer constitutes 22 per cent of the new cases of cancer in women while the overall five-year survival rate for this type of the disease is 40 per cent.

Selection of cancer of the cervix as the subject for this year's symposium follows the policy introduced several years ago of devoting an entire program to a single type of malignancy rather than to attempt a program in which brief attention was given to a number of different types. Last year the discussion centered on cancer of the breast.

Participating in the symposium will be:



A. N. Arneson, M.D.,

Professor in Clinical Obstetrics and Gynecology, and Associate Professor in Clinical Radiology, Washington University School of Medicine, St. Louis; "*Radiation Therapy of Carcinoma of the Cervix.*"



Alexander Brunschwig, M.D., Professor of Clinical Surgery, Cornell University College of Medicine, and Attending Physician, Memorial Center for Cancer and Allied

Disease, New York City; "*Surgery in Advanced Carcinoma of the Cervix.*"

David N. Danforth, M.D.,

Chairman, Department of Obstetrics and Gynecology, Evanston (Ill.) Hospital, and Associate Professor of Obstetrics and Gynecology,



Northwestern University Medical School; "*Epithelial Changes in the Cervix During Pregnancy.*"



John L. McKelvey, M.D., Chairman and Professor of Obstetrics and Gynecology, University of Minnesota Medical School; "*Surgery in the Management of Endometrial Carcinoma.*"

Norman F. Miller, M.D., Chairman and Professor of Obstetrics and Gynecology, University of Michigan Medical School; "*Preoperative Radiation in the Management of Endometrial Carcinoma.*"



Daniel G. Morton, M.D., Chairman and Professor of Obstetrics and Gynecology, University of California School of Medicine; "*Surgical Management of Cervical Carcinoma.*"



Richard W. Te Linde, M.D., Professor in Gynecology, Johns Hopkins University School of Medicine, and Chief Gynecologist, Johns Hopkins Hospital; "*Carcinoma in Situ of the Cervix.*"



Emil Novak, M.D., Assistant Professor Emeritus Gynecology, Johns Hopkins Medical School, Gynecologist in Chief, Bon Secours and St. Agnes Hospitals; "*The*

Relationship Between Endometrial Hyperplasia and Carcinoma."

The symposium is again being presented by the Indiana University School of Medicine as a part of its postgraduate program, and again has the support of the Indiana Division of the American Cancer Society.

The speakers being heard March 4 will compose the Telephone Seminar panel for a roundtable discussion of cancer in the evening, Tuesday, March 3. This program, a joint postgraduate activity on the part of the School of Medicine and the Indiana State Medical Association, will be carried by long distance lines to meeting places of various county medical societies.

Physicians are invited to submit in advance, questions for discussion on the Telephone Seminar program, such questions to be addressed to: Cancer Committee, Indiana University Medical Center, 1040-1232 West Michigan Street, Indianapolis. Physicians are also invited to be present in the Medical School auditorium during the seminar program.

PROGRAM

Morning Session

- 8:30 Registration.
- 9:00 Welcome—Dean John D. VanNuys.
- 9:15 "Carcinoma In Situ of the Cervix."
Richard W. TeLinde, M.D.
- 10:00 "Epithelial Changes in the Cervix During Pregnancy."
David Danforth, M.D.
- 10:45 "The Surgical Management of Cervical Carcinoma."
Daniel G. Morton, M.D.
- 11:30 "Radiation Therapy of Carcinoma of the Cervix."
A. N. Arneson, M.D.

LUNCHEON

Afternoon Session

- 1:45 "Surgery in Advanced Carcinoma of the Cervix."
Alexander Brunschwig, M.D.
- 2:30 "The Relationship Between Endometrial Hyperplasia and Carcinoma."
Emil Novak, M.D.
- 3:15 "Surgery in the Management of Endometrial Carcinoma."
John L. McKelvey, M.D.
- 4:00 "Preoperative Radiation in the Management of Endometrial Carcinoma."
Norman F. Miller, M.D.

DELEGATES REPORT A.M.A. SESSION, DENVER, DECEMBER 2-5, 1952

CLEON A. NAFE, M.D.

Indianapolis

DOCTOR-DRAFT APPROVED WITH "CONDITIONS"

EVERY draft-eligible physician in the United States was undoubtedly watching with concern the AMA House of Delegates for a decision on continuation of the "doctor-draft" law (Public Law 779), due to expire on July 1, 1953. The AMA's position was conceived in a stormy reference committee session that lasted throughout the day, but was approved without debate on the floor. In the resolution as finally adopted the Council on National Emergency Medical Service was instructed to support legislation "to provide the number of medical officers required to care adequately for the health needs of the **uniformed** armed forces," but on the following conditions:

1. Revision of physical requirements for medical officers so that physicians with physical defects be placed on military duty with appropriate assignments.
2. Development of better recruitment meth-

ods by the Armed Forces for Regular Medical Corps personnel.

3. Greater use of civilian doctors and hospital facilities for care of both military and non-military personnel and dependents of servicemen.
4. More economical and efficient use of physicians in all governmental agencies.
5. Establishment of more uniform "conditions of service" among the several government agencies to put an end to "undue competition" for medical personnel.
6. Establishment of an "equitable point system" for the call-up of physicians.

Throughout reference committee debate on the doctor-draft, physicians insisted the AMA take a positive stand against the use of involuntary call-up of physicians for the care of civilian dependents of servicemen. Hence the importance of the word "uniformed" in the resolution.

ARGUE MILITARY NEEDS FOR MDs

When the AMA session began, the Board of Trustees endorsed the Council on National Emergency Medical Service recommendation that no action be taken on the doctor-draft issue until the AMA received more information on the need for physicians in the Armed Forces. A joint statement by the Deputy Surgeons General

of the Army, Navy and Air Force said there must be some "misunderstanding." They reported having given full information on the need for and use of physicians for the past several years. In addition, they said even "a total cease-fire in Korea would reduce medical officer requirements by not more than five per cent."

QUESTION CARE OF DEPENDENTS

The Council on National Emergency Medical Service has contended that too many military physicians are being used for the care of servicemen's dependents. The formal reply of the Armed Forces representatives indicated that "only 8 per cent of all inpatient care and 20 per cent of outpatient treatments stem from the care of dependents." On the other hand, Deputy Surgeon General of the Army Silas B. Hayes estimated that the dependents of "approximately

60 per cent of the Army's personnel are being cared for by military physicians. The military contends it must provide care to dependents in overseas theatres and in isolated areas of the U. S., and that its research, intern and residency programs, and recruitment appeals get much of their strength from the fact that all types of patients can be seen by military physicians. The House asked Congress to study whether dependents of servicemen are proper recipients of "free" care by the military.

HINTS ON NEW DRAFT LAW

Out of the reference committee debate came word of plans for continuation of the "doctor-draft" along new lines. An *ad hoc* committee of the Armed Forces Medical Policy Committee has made the following preliminary proposal:

1. Abolish the four priorities. Instead divide all special registrants into two groups:
 - a. All persons who have not served on active duty. Inductions from this group should be on the basis of age, youngest being called first.
 - b. Persons who have served. Inductions from this group should be on the basis of prior service, least amount of service being called first.

2. Whenever a Special Registrant previously classified in Priority I or II becomes available for duty, such person should be inducted ahead of any others not so classified.

3. No person who has served on active duty for 12 months or more subsequent to 25 June 1950 shall be liable for further induction.

It should be remembered that these are not official recommendations at this point. They do, however, give some indication of the thinking of Selective Service and the Armed Forces on the future of the doctor-draft.

DEFER PRIORITY III CALL

The House of Delegates also adopted a resolution urging that the President of the United States defer any call-up of Priority III physicians under Public Law 779 until the Selective

Service System and the Department of Defense have completed the call-up of all physicians in Priorities I and II except the "occasional individual who is considered essential."

APPROVE SPECIAL PAY

The House reiterated its approval of the \$100 per month special pay for physicians in the Armed Forces. It also urged the AMA to call

an early meeting of state chairmen of advisory committees to Selective Service to get their thoughts on future doctor-draft legislation.

VETERANS' CARE ALSO ISSUE

Following fervent debate on the question of VA care for veterans with non-service-connected disabilities, the issue remains unsettled. A decision was reached to study the matter further and report to the June 1953 meeting of the House. However, agreement was reached on several related items which were examined in a year-long study by the AMA's Special Committee on Federal Medical Services, also known as the Martin-Henderson committee. All but one section of the recommendations of the Special Committee were adopted. They asked that:

1. New legislation be enacted limiting the medical care and hospitalization benefits for veterans in VA and other federal hospitals to:

- a. Veterans with service-incurred or aggravated disabilities.
- b. Veterans with tuberculosis or psychiatric or neurological disorders of

non-service-connected origin and who are unable to defray the expenses of necessary treatment.

2. Congress study and determine whether the provisions of medical care and hospitalization benefits for dependents of service personnel is "a proper and desirable emolument of military service."
3. Continuation of present policy of transferring seriously disabled service personnel from service hospitals to Veterans Administration installations.

The House rejected a controversial paragraph which recommended that medical and hospital care for all non-service-connected disabilities be discontinued, with the exception of TB or neuropsychiatric cases. The Martin-Henderson report stated that the responsibility for the care of such veterans should "revert to the individual and the community, where it rightfully belongs."

SEEK "REASONABLE CONCLUSION"

Instead, the House agreed that complete discontinuance of the care of non-service-connected cases could not be accomplished without the cooperation of Congress, veterans organizations, and the medical profession. Accordingly, it adopted a resolution recommending that the

AMA, veterans groups, American Dental and Hospital Associations, VA and Department of Defense "sit down and try to reach reasonable conclusions for appropriate action from agreed data rather than take any precipitate action now."

VA AND LEGION INFLUENCE FELT

Undoubtedly the testimony of Dr. Joel T. Boone, chief medical director of the VA and former member of the House of Delegates, and Dr. Norman R. Booher, of Indianapolis, representing the National Commander of the American Legion, had considerable impact upon the decision of the House. Dr. Boone stated the

Martin-Henderson report was "too intricate and involved for the House to vote on it hurriedly." Dr. Booher pointed out that "tampering" with the law would be dangerous, but said the American Legion stood ready to join the AMA in efforts to prevent "chiseling" non-service-connected cases from receiving VA treatment.

ATTENTION CALLED TO INDIANA PLAN

The reference committee in making its report called attention to the plan instituted in Indiana on November 23, 1952 at which time representatives of the American Legion, the medical profession, the hospital association and the den-

tal profession met for a full discussion of this problem. The committee recommended that other states would do well to institute such a program within their state, which should help bring about a solution of this problem not only at the local level but also at the national level.

INDIANA RESOLUTION CREATES NURSING STUDY

A resolution introduced in the Indiana House of Delegates by the Tippecanoe County Medical Society was introduced in the AMA House of Delegates in accordance with the action of the Indiana House.

Criticism that the accrediting of schools of nursing is based upon "Educational Minutiae" which "are hampering and handicapping the training of the necessary number of nurses" was received by the House of Delegates and resulted in the adoption of a resolution to study the entire nurses' training and accreditation program. The Indiana action opened the subject with a resolution contending that:

1. An important factor in nurse recruitment is the availability of schools of nursing at no great distance from the home of young women desiring to take such training.
2. The plan for accrediting schools of nursing

as developed by the National Nursing Accrediting Service is "based upon educational minutiae applicable to certain nurses training institutions in some parts of the U. S., but wholly inapplicable to present excellent nurse training programs in other sections of the U. S." and is "hampering and handicapping the training of the necessary number of nurses to meet present needs."

Acting in accord with the Indiana resolution, the AMA House of Delegates requested the Board of Trustees to institute a study of nursing with emphasis on number needed and supply, the accreditation program for schools of nursing, and the possibility of shorter training periods for R.N.'s, less stringent requirements concerning teachers, and greater use of trained practical nurses. The Trustees are to report back to the House in June 1953.

AMA PRESIDENT SUGGESTS PLAN TO OBTAIN MORE G.P.'s

Dr. Louis H. Bauer, Hempstead, N. Y., president of the American Medical Association, spoke out plainly in favor of revision of specialty board requirements as a means of improving the supply of General Practitioners. He pointed out that U. S. medical schools are now turning out physicians at a faster rate than the population is increasing, but he warned that steps must be taken to remedy the situation of isolated areas where there is a shortage of physicians. He recommended two steps:

1. Encourage communities to establish facilities for a physician to practice good medicine.

2. Urge the specialty boards to revise their requirements.

"The present system results in more men going into specialties than is desirable . . . and practically prevents a general practitioner from becoming a specialist," Doctor Bauer declared. He suggested that general practice be established as one of the requirements for at least the majority of special fields.

Carrying out this suggestion, the House of Delegates ordered appointment of a committee to work with the Advisory Board on Medical Specialties on means of increasing the number and distribution of general practitioners. A report will be made at the June 1953 meeting of the House in New York.

HOUSE CONDEMNS "COMMERCIALISM" IN MEDICAL PRACTICE

Doctor Bauer hit sharply at what he called "commercialism" in the practice of medicine. "If the offenders against the ethics and traditions of medicine are not willing to cease unethical practices they must be expelled from organized medicine. Such action would only have to be taken a few times and commercial practices would stop."

The House of Delegates went on to approve his stand and recommended that:

1. State Associations be adamant in disciplin-

ing unethical members and establish more rigid ethical requirements for membership.

2. Medical schools should provide lectures and other training in ethics and traditions of medicine to all students.
3. The House of Delegates be recorded as "Thoroughly disapproving of any arrangement between pharmacists and physicians."

Doctor Bauer and the House declared: "We must let the public know that we will not tolerate unethical actions."

URGE CARE FOR ANYONE UNABLE TO PAY

The House adopted a statement of the Board of Trustees urging physicians to provide medical care to anyone unable to pay for it. The statement said in part: "Protests have been made . . . that medical care is being denied certain individuals because of its cost . . . the prime object of the medical profession is to serve

humanity, regardless of reward . . . with a view to implementing this principle, a number of county medical societies have successfully conducted and publicized programs offering to provide the services of a physician to anyone unable to pay for it . . . state medical societies are encouraged to organize and vigorously promote similar campaigns."

REVISE ESSENTIALS OF APPROVED INTERNSHIPS

Important alterations of the essentials of approved internships were adopted by the House of Delegates upon recommendation of the Reference Committee on Medical Education and Hospitals. The revisions emphasize the educational aspects of internship. Any hospital which uses interns as a convenience for the staff or the hospital will not be approved for internships,

the House agreed. In brief, the new essentials permit rotating internships only in general hospitals having at least 150 beds and a minimum of 5,000 annual admissions. Hospitals will be allowed one intern for every 15-25 beds depending upon the type of patients. Private patients may be counted toward the total patient capacity, provided they are used for teaching purposes.

RECOMMEND DEPARTMENT OF HEALTH WITH CABINET STATUS

Creation of a federal department of health with cabinet status was approved by the House of Delegates at its final session. The resolution

was introduced by Dr. Russell V. Lee, California, active member of the President's Commission on the Health Needs of the Nation.

AMA SEEKING TAX RELIEF FOR MD's

AMA efforts to achieve some measure of tax relief for physicians were endorsed by the House of Delegates. The AMA is seeking reversal of rules that expenses of postgraduate study are not deductible for federal income tax purposes. During the 83rd Congress, the AMA will continue efforts to procure passage of bills allowing

physicians to set aside retirement funds out of current income without paying taxes on such funds until the benefits are received. It also seeks revision of federal internal revenue laws, including income tax laws, to eliminate or minimize inequities affecting the physician as well as others.

URGE CONFERENCE WITH OSTEOPATHS ON TEACHING

An AMA committee was instructed by the House to consult immediately with the American Osteopathic Association concerning the use of physicians as instructors in osteopathic schools. It is to report results at the June 1953 meeting

of the House. Members of the AMA committee are Drs. John W. Cline, San Francisco; F. J. L. Blasingame, Wharton, Texas; E. S. Hamilton, Kankakee, Illinois; and J. P. Wall, Jackson, Mississippi.

OTHER HIGHLIGHTS OF DENVER SESSION

AMA's Committee on Blood Banks warned that gamma globulin "does not provide a practical solution to the problem of preventing paralytic polio," and the meager supply of gamma globulin should be conserved for emergency use.

. . . Dr. Louis A. Buie, Rochester, Minnesota, member of the AMA Judicial Council, urged interested physicians to send him suggestions for improving and modernizing the Principles of Medical Ethics, particularly with regard to fee-splitting and advertising and publicity.

ACTION ON OTHER ITEMS

The House of Delegates deferred making a clear-cut definition of dental and medical care . . . opposed use of prisoners for scientific experiments as a means of gaining leniency . . . favored U.S. withdrawal from the ILO (a division of United Nations) on the basis that it is socialistic and its treaty actions may supercede the U. S. Constitution . . . contributed \$500,000 to the American Medical Education Foundation for support of medical schools . . . condemned as a form of fee-splitting the practice of some hospitals requiring physicians to pay a percentage of fees received from patients served in hospitals . . . named Dr. John Travis of Texas as the "GP" of the year . . . decided there is

no need for AMA Health Commission similar to President's Commission on grounds that various AMA departments do the job . . . asked each state to obtain a precise definition of the role of government in provision of medical services to various elements of the population . . . turned down the Indiana resolution suggesting grass-roots educational campaign calling attention to the dire implication of Sec. 3 of P. L. 590, on the basis that the law was inoperative as now written and this section would expire before it became effective . . . stated the problem of reducing the number of required meetings was a local problem and should be settled at the local level.

Doctors from Indiana who attended the session were: Henry H. Alderfer, Marion; Lawrence S. Bailey, Zionsville; James H. Bivin, Indianapolis; Edgar H. Black, Wabash; Norman R. Booher, Indianapolis; Harold D. Caylor, Bluffton; Franklin S. Crockett, Lafayette; Richard M. Davis, Marion; Frank T. Denny, Ladoga; Henry Fisher, Marion; Gladys D. Frith and L. G. Frith, South Bend; John H. Greist, Indianapolis; John J. Hardy, North Liberty; W. Harry Howard, Hammond; Carl Milton Hostetler, Goshen; Wilbur J. Irish, East

Chicago; Clifford M. Jones, Whiting; J. W. Justen, Hammond; Clarence G. Kern, Lebanon; William R. Kirtley, Indianapolis; N. W. Kriebel, Terre Haute; Otto F. Lehnberg, Columbia City; Bill L. Martz, Indianapolis; Robert M. Maurer, Brazil; Milo G. Meyer, Michigan City; Cleon A. Nafe, Indianapolis; George Plain, South Bend; Karl R. Ruddell, Indianapolis; R. L. Sensenich, South Bend; Wendell C. Spalding, Mishawaka; Murray Stasick, Hammond; Wendell C. Stover, Boonville; James H. Stygall, Indianapolis; W. W. Washburn, Lafayette; Mell B. Welborn, Evansville.

HOUSE ACTION ON DOCTOR-DRAFT LAW OUTLINED BY A.M.A. SECRETARY

TO CLARIFY what I said in my December 10 letter relative to the doctor draft law, the House of Delegates, meeting at the Clinical Session in Denver, adopted a resolution which followed in part the proposals offered by the Pennsylvania State Medical Society.

The reference committee report as adopted by the house said:

Resolved, That for the interim until the next regular meeting of the House of Delegates, the Board of Trustees and the Council on National Emergency Medical Service are authorized and directed as follows:

1. To follow closely all developments, both national and international, which might affect the quantitative requirements of the armed forces for medical officers.

2. To support legislation designed to provide the number of medical officers required to care adequately for the health needs of the uniformed armed forces, which will, so far as consistent with the public interest, guard the following principles:

- A. Physical requirements for medical officers should be realistically revised to the end that physicians with physical defects be utilized with appropriate assignment.

- B. More effective recruitment methods should be developed for career personnel in military medicine; and the Armed Forces Medical Policy Council's efforts in this direction should be supported.

- C. The greater use of civilian doctors of medicine and civilian hospital facilities, whenever and wherever feasible, in the care of both military and non-military personnel and dependents of military personnel, should be encouraged.

- D. Since the total number of doctors of medicine available to the various governmental agencies and for the general health needs of the nation, is an irreplaceable pool of relatively fixed proportion, it must be utilized in the most economical and efficient manner.

- E. Conditions of service in the several governmental agencies should be sufficiently uniform to avoid undue competition for medical personnel.

- F. Consideration should be given to an equitable point system in the induction of doctors of medicine into the medical departments of the armed services.

- G. In regard to the operation of the existing doctor draft law, the President of the United States should be requested by the A.M.A. to defer any call-up of Priority III physicians under Public Law 779 until the Selective Service System and the Department of Defense have completed the processing of all physicians in Priorities I and II and have called to active military service all physicians in these groups except those very occasional individuals whose further deferment is essential to the nation's health, safety and interest.

GEORGE F. LULL, M.D., *Secretary*
American Medical Association

A.M.A. PRESIDENT LISTS MEDICINE'S MAJOR OBJECTIVES FOR 1953

WITH the dawn of a new year, Dr. Louis H. Bauer, Hempstead, N. Y., president of the American Medical Association, outlined a constructive nine-point program for what he called "the preservation of our American system of medicine." His nine points, directed to all physicians and to all component societies of the A.M.A., are:

1. Work with rural communities to establish facilities for physicians, so that we shall have a better distribution of physicians.
2. See that good medical care for the indigent is available everywhere, just as it is in some states.
3. Extend public health coverage to areas lacking it.
4. Develop plans for the care of the chronic invalid.
5. Expand our voluntary insurance program, not only to cover more persons, but to cover those over age 65 and those suffering from illness of long duration.
6. Clean our own house, by disciplining those physicians who are tarnishing the reputation of the whole profession by their unethical acts of overcharging, accepting kick-backs, and making commercial arrangements with pharmacists.
7. See that the public is protected so that they can always obtain the services of physicians.
8. Revitalize our county societies and make them leaders in their communities in all health matters.
9. Inculcate the newly trained physicians in the traditions and ethics of medicine.

Dr. Bauer said that there also are "certain legislative matters that will require our attention and earnest study." He listed them as follows:

1. The establishment of a department or independent agency of health in the federal government. It must not be tied in with education or social security. Health is important enough to warrant an agency by itself.
2. The making of constructive suggestions for the solution of the problem of the totally disabled under the social security law.
3. Obtaining sufficient physicians for the armed forces, without injustices or upsetting civilian medical care programs.
4. Enactment of a law allowing pensions or retirement privileges for the self-employed, along the lines of the Reed-Keogh bill introduced in the last Congress.

"Another matter, which may not require legislation," Dr. Bauer said, "is a solution of the problems related to the Veterans Administration.

"These are a few of the matters that will engage our activities in the immediate future. They will require the labors and cooperation of all our constituent and component units, as well as the support of the individual members of the profession. A united profession can accomplish much, while a disunited profession can accomplish nothing."

POPULAR COLUMNIST SAYS UPKEEP OF HUMAN "CHASSIS" RELATIVELY LOW

REPRINT rights, without charge, have been granted to THE JOURNAL of the Indiana State Medical Association permitting use of the following column by the widely read writer-teacher-physician, Dr. George W. Crane.

The Worry Clinic

The "parallel comparison" method is excellent in salesmanship as well as logical debate. Compare your very valuable human machine with your automobile, and then see if you are straining at a gnat but swallowing a camel. Don't wince at a modest charge to keep you alive, and then gladly sink a small fortune in a fancy funeral. Use your "horse sense."

By Dr. George W. Crane

Case F-316: Don M., aged 36, recently took his wife to the hospital for a surgical operation.

"She recovered very nicely and had excellent treatment during her two weeks there," he admitted.

"But it seems to me that the hospital bill was pretty steep. I had to pay \$8 per day for her room, and also an additional charge for the operating room, the anesthesia, and all drugs used.

"On top of all of this, the surgeon's bill is still to be met. Dr. Crane, it seems to me that it would be much better if the government or the state ran the medical profession."

Be Logical

Don's attitude shows clearly why medicine, as well as dentistry, should begin publicizing their services by group sponsored newspaper ads.

"You must tell 'em if you want to sell 'em," runs an adage of Applied Psychology, that is just as applicable to medicine and dentistry as to refrigerators or life insurance.

Americans are accustomed to paying \$5 for a single room at a downtown hotel. This figure includes no meals, and no sponge baths by a nurse, nor alcohol rubs, taking of temperature, etc.

A modern hospital furnishes good meals and even lets the patient select his or her foods from a printed menu card.

Hotels which operate on the American plan, meaning that meals are included with the room charge, normally ask from \$8 to \$15 per single room.

The average hospital is thus operating on a cheaper room charge than our hotels, if we include all the extra services offered by the hospital room.

Parallel Comparisons

In salesmanship, as well as logical arguments, it is good strategy to make parallel comparisons, as I have done between hospitals and hotels.

We might continue this method by pointing out the fact that Americans are accustomed to paying \$275 or more for a refrigerator. They will think nothing of sinking \$1,200 in a jalopy or used car.

And after a member of the family is dead, they may spend \$750 for the funeral, without complaining about the cost.

Recently some acquaintances of mine objected to a \$15 per day oxygen tank to help their father withstand an attack of pneumonia.

But when he died a week later, they spent \$675 for his casket and funeral, but I never heard them say a word to the effect that it was expensive.

We human beings are a curious lot, for we seem to be habitually averse to spending money to keep us alive, but gladly invest large sums for burials.

Play Fair

Men will change oil in their automobile every 1,000 miles and have a garage check it for winter and summer grease jobs.

But they will let their far more valuable human machine run until it breaks down before they are willing to spend a cent for medical attention. Even then they may wince at a \$5 fee.

How long have you readers gone without having your eyes tested? Have you voluntarily visited a dental office within the last year?

Have you valuable heads of families received a good physical examination lately? If not, why don't you play fair with your bodies and apply the old adage that a stitch in time saves nine?

Even a pick and shovel laborer is worth \$100,000 in wages during his adult lifetime,

while you business and professional men may be worth at least half a million in useful service.

So don't object too strenuously to a hospital bill of \$100. Don't strain at a gnat and swallow a camel!

You spend \$50 upkeep on a \$500 jalopy, so why yell at \$100 to keep a \$250,000 human chassis in good running order?

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News Notes



REPRESENTATIVES of the Indiana State Dental Association, the Indiana Hospital Association, the Indiana State Medical Association, the Indiana State Nurses' Association, the Indiana Pharmaceutical Association, the Indiana Veterinary Medicine Association, Butler University College of Pharmacy, Purdue University School of Pharmacy, Indiana University School of Medicine and the Indiana State Board of Health, pictured above, met recently in the Columbia Club, Indianapolis, to orient new members of the Indiana Interprofessional Health Council and discuss legislative matters in which the member associations are interested.

Those pictured from left to right are: back row, Genevieve L. Beghter and Marie Winkler, Nurses' association; E. E. Ewbank, Dental association; Glenn L. Jenkins, Purdue School of Pharmacy; L. E. Burney, State Board of Health; E. Nancy Scramlin, Nurses' association. In front of speakers' table, left to right, first row, William Hartnett, Nurses' association; J. W. Green, Veterinary association; M. E. Clark and George M. Ellis, Medical association; second row, T. H. Brown, Veterinary association; Edward L. Mitchell, Dental association; K. L. Kaufman, Butler School of Pharmacy; third row, C. T. Mayfield and Ralph E. McDonald, Dental association; fourth row, Bernard F. Carr, Hospital association; J. B. Lischke, Pharmaceutical association; fifth row, M. B. Catlett, Medical association; Herbert H. Gerding, Pharmaceutical association; Dr. Thurman B. Rice (deceased), Indiana University School of Medicine; and James A. Waggener, executive secretary, Indiana State Medical Association.

Dr. George R. Daniels to Be Honored at WMA Conference

Dr. and Mrs. George R. Daniels of Marion will be Indiana's guests of honor at the First Western Hemisphere Conference of the World Medical Association, to be held in Richmond April 23 to 25, 1953, in observance of the lengthening of life and the constant improvement of human health.

Governor Henry F. Schricker of Indiana told Governor John S. Battle of Virginia of the selection of Dr. Daniels, whom he described as "a highly respected practitioner of his community." Recently Governor Battle asked each of his 47 fellow-Governors to appoint a physician who will reach the age of 75 during 1953 to visit Virginia and tell of medical advances that have taken place during his lifetime.

Dr. Daniels of 822 West Fourth Street, Marion, has been in general practice for more than 50 years. He was born in 1878, the year when pioneering Robert Koch published a history-making treatise on causes of infection, opening the way to rapid progress in various fields of medicine. Dr. Daniels was graduated in 1900 from the Medical College of Indiana which later became a part of the School of Medicine, Purdue University. He is a past president of the Indiana State Medical Association.

At the Richmond conference, guests will be greeted by Dr. Louis H. Bauer, president of the American Medical Association, and by leaders of Latin American medical societies. Besides scientific sessions, there will be opportunities for visiting historic sites in Virginia, including the 18th century Williamsburg restoration. Expenses of the conference, and of guests and delegates, are covered through a grant by A. H. Robins Co., Inc., ethical pharmaceutical house founded in Richmond 75 years ago this year.

Dr. James H. Crawford, Evansville, has been named chief of staff at Deaconess hospital in that city to serve during 1953. Dr. Willard Barnhart was named vice-president and Dr. Joseph Coleman reelected secretary-treasurer.

The Annual Assembly of the **National Academy of General Practice** will be held March 23 through March 26 in St. Louis. Headquarters will be established in the Hotel Statler. The first International Congress of General Practice will be held in Mexico City March 26 through April 10. Dr. Norman R. Booher, 447 East 38th Street, Indianapolis, secretary of the Indiana Academy, has full details of both meetings.

The American Society for the Study of Sterility announces the opening of the **1953 contest for the most outstanding contribution to the subject of infertility and sterility**. The winner will receive a cash award of \$1,000, and the essay will appear on the program of the 1953 meeting of the Society. Essays submitted in this competition must be received not later than March 1, 1953. For full particulars concerning requirements of this competition, address The American Society for the Study of Sterility, c/o Dr. Herbert H. Thomas, 920 South 19th Street, Birmingham, Alabama.

The author should append on a separate sheet of paper a short biographical sketch of himself and include a photograph to be used in the necessary publicity should he be the winner of the award.

Results of two industrial hazards investigated by the Division of Industrial Hygiene of the Indiana State Board of Health are given in the December issue of Occupational Health, a publication of the Public Health Service.

Dr. Louis W. Spolyar, director of the division, is the author of the two articles which are on kiln operators receiving skin burns from sand high in carbonates, and on the development of lead poisoning while cleaning automobile engines with a carbon-blasting machine.

Dr. Howard A. Rusk, New York, has been named as the 1952 winner of the \$10,000 Dr. C. C. Criss Award and gold medal in recognition of his work in rehabilitating the physically handicapped.

The award was established by Mutual Benefit Health and Accident Association of Omaha to honor outstanding contributors to the fields of health and safety.

Qualifying examinations for Fellowship in the United States Section of the International College of Surgeons will be held on the following dates in 1953: February 2 and 3, May 4 and 5, August 10 and 11, and November 2 and 3. The examinations will be given at the Cook County Graduate School of Medicine, and the Cook County Hospital. Applicants are requested to address communications as follows: Harry A. Oberhelman, M. D., Secretary, Qualification and Examination Council, 1516 Lake Shore Drive, Chicago 10, Illinois.

The Thirteenth Annual Essay Contest of the Mississippi Valley Medical Society will be held in 1953. The Society will offer a cash prize of \$100, a gold medal, and a certificate of award for the best unpublished essay on any subject of general medical interest (including medical economics and education) and practical value to the general practitioner of medicine. Certificates of merit may also be granted to the physicians whose essays are rated second and third best. Contestants must be members of the American Medical Association who are residents and citizens of the United States. The winner will be invited to present his contribution before the Eighteenth Annual Meeting of the Mississippi Valley Medical Society to be held in Springfield, Ill., Sept. 23, 24, 25, 1953, the Society reserving the exclusive right to first publish the essay in its official publication, the Mississippi Valley Medical Journal (incorporating the Radiologic Review). All contributions shall be typewritten in English in manuscript form, submitted in five copies, not to exceed 5,000 words, and must be received not later than May 1, 1953. The winning essays in the 1952 contest appear in the January, 1953, issue of the Mississippi Valley Medical Journal (Quincy, Ill.).

Further details may be secured from: Harold Swanberg, M. D., Secretary, Mississippi Valley Medical Society, 209-224 W. C. U. Building, Quincy, Illinois.

Lt. Col. H. H. Ziperman, member of the Indianapolis Medical Society and formerly at the Indiana University Medical Center, returned to the United States recently for a short period of temporary duty in order to present a statistical survey on arterial injuries among combat troops in Korea where he is serving as surgical consultant for the 8th Army. Colonel Ziperman presented his findings before the Sub-Committee on Shock of the National Research Council in Washington, D. C., on December 9. After a series of conferences with personnel of the Surgeon General's office on surgical problems in Korea Colonel Ziperman returned to duty.

Dr. Paul E. Strueh, who has been in practice in Evansville since July, 1951, has been certified by the American Board of Otolaryngology as a diplomate in ear, nose and throat practice. Doctor Strueh, whose education was interrupted by military service between 1946 and 1948, is a graduate of Chicago University School of Medicine, interned at Presbyterian hospital, Chicago, served at the Research and Education hospital, Chicago, Illinois Eye and Ear Infirmary at Cook County hospital and at Hines hospital, Chicago.

Dr. Richard Silver, who has been assistant radiologist at Indiana University Medical Center during the last year, recently passed American Board of Radiology examinations and has now become associated with Ball Memorial hospital, Muncie, working with Dr. B. W. Stocking as radiologist. Doctor Silver is a graduate of Indiana University School of Medicine, interned at Rochester, New York, General hospital, served two years in the army in Korea and completed his residency at the Indiana University Medical Center.

After completing his internship at Good Samaritan and Maricopa County hospitals in Phoenix, Arizona, **Dr. James R. Mensch** has returned to Fort Wayne where he has begun the

general practice of medicine and surgery in association with Dr. Gerald H. Somers. Doctor Mensch is a 1951 graduate of the Indiana University School of Medicine and previously served three years in the U. S. Army.

Dr. Pasquale G. Damiani, formerly in private practice in Philadelphia, has taken over the practice of Dr. C. F. Worrell, Peru, who recently retired. Doctor Damiani also taught surgery at Hahnemann Medical College, Philadelphia.

Indiana University News Notes

Indiana physicians and surgeons are invited by the Indiana University School of Medicine, to attend a weekly series of neurosurgical conferences and clinics beginning Friday, February

13, on the Indiana University Medical Center campus in Indianapolis.



Dr. Bucy

The conferences and clinics will be conducted by Dr. Paul C. Bucy, distinguished Chicago neurosurgeon, and George A. Ball Visiting Professor in Surgery. Doctor Bucy will begin his series of visits to the Medical Center on Friday, February 13, returning each succeeding Friday for a period of months.

Doctor Bucy's program will open at 9 o'clock each Friday morning with a conference on current neurosurgical cases, covering both diagnostic and therapeutic problems. From 2 until 3 o'clock in the afternoon Doctor Bucy will conduct a neurological and neurosurgical teaching clinic. During the following hour he will join with Dr. Orville T. Bailey, neuropathologist on the Medical School staff, in presenting a neurological and neurosurgical clinical pathological conference.

Physicians are invited to attend any or all of these programs each Friday, beginning with February 13. In the event that evening programs or other special events are arranged, these, too, will be open to all physicians.

Doctor Bucy, Professor of Neurology and Neurological Surgery at the University of Illi-

nois School of Medicine, is also chairman of the AMA Section on Nervous and Mental Diseases and secretary of the American Board of Neurological Surgery. He is widely known for his professional publications and as the co-author of various textbooks. In addition Doctor Bucy is chief of staff at Chicago Memorial Hospital.

In addition to Doctor Bucy, the Visiting Professorship will be held by such outstanding men in the neurological and neurosurgical field as Dr. R. Eustace Semmes, Professor of Neurological Surgery at the University of Tennessee who will come to the I. U. Medical School during the week of April 12; and Dr. Percival Bailey, Professor of Neurology and Neurological Surgery at the University of Illinois School of Medicine, who will be on the Medical Center campus the week of May 12. Dr. Franc D. Ingraham, Professor of Neurological Surgery at Harvard University School of Medicine, will fill the Visiting Professorship on dates to be announced later.

The George A. Ball Visiting Professorship in Surgery was established at the Indiana University School of Medicine late last year by the James Whitcomb Riley Memorial Association, as a tribute to Mr. George A. Ball, Muncie industrialist and philanthropist. Mr. Ball is a charter member of the Riley Memorial Association and served for a number of years as a trustee of Indiana University. He and members of his family have contributed materially to the development of the University Medical Center, providing Ball Residence and Annex for nurses' housing and training, in addition to aiding in the erection of the Riley Hospital for Children.

Deaths

Thurman B. Rice, M. D., for many years a leading figure in Indiana and the nation in the field of public health, died December 27 from a heart ailment which had restricted his activities



for the last year. Doctor Rice was a native of Grant county, born in 1888, and a graduate of the Indiana University School of Medicine in 1921. After his graduation he joined the Indiana University faculty, serving as an assistant in pathology from 1921-24. From 1924-26

he directed the laboratory of the Indiana State Board of Health; in 1926-27 was professor of bacteriology at the I. U. School of Medicine and since 1926 served there as professor of public health. When the school established a Department of Public Health in 1946 he was made its director. In addition to his teaching and administrative duties at the Medical Center, Doctor Rice served between 1942 and 1945 as Indiana State Health Commissioner. Since 1933 he had edited the Monthly Bulletin of the Indiana State Board of Health.

Certified by the American Board of Pathology, Doctor Rice was a member of the College of American Pathologists. He was a member of the American Public Health Association, the Indianapolis Medical Society, the Indiana State and American Medical Associations.

Doctor Rice had served on many committees of the Indiana State Medical Association. On three different occasions he was elected to the Editorial Board of *THE JOURNAL* and re-elected each time for periods of two and three years. Since 1928 he had been a frequent contributor to *THE JOURNAL*. In 1949 when the state association celebrated 100 Years of Medicine in Indiana Doctor Rice served as chairman of the Committee on History and the Committee on Historical Exhibits. For the last three years he had been on the Committee on Scientific Exhibits.

Throughout his career, Doctor Rice made friends for the medical profession and made public health an attractive and understandable subject through his lectures and prolific writing.

Charles A. Pfafflin, M. D., 79, died December 30 in Indianapolis where he had practiced medicine for 50 years before his retirement. He was made a member of the Indiana State Medical Association's Fifty Year Club in 1950. A native of Ohio, Doctor Pfafflin came to Indianapolis from Cincinnati in 1899. He was a graduate of the Medical College of Ohio in 1893; a specialist in ophthalmology, otology, laryngology, and rhinology, certified by the American Board of Otolaryngology and a member of the American College of Surgeons, the Indianapolis Medical Society, the Indiana State and American Medical Associations.

William D. Schwartz, M. D., 82, Portland physician and surgeon for 56 years, died December 28 in Portland after a year's illness. Doctor Schwartz was widely known in his home community where for many years he was the only practicing surgeon and where he had been active in many civic undertakings. Internationally, he gained fame in 1900 when he performed the first double tonsillectomy with local anesthetic in England where he was studying surgery at St. Bartholomew's hospital, London. Doctor Schwartz was a graduate of the Medical College of Indiana, Indianapolis, in 1896 and established his practice in Portland in 1897.

Clarence S. Baker, M. D., 70, Evansville, died December 14 after being hospitalized one week. Born in Warrick county, he was graduated from Louisville Medical College in 1906 and established practice in Chrisney. He later practiced in Princeton before going to Evansville in 1917. He was associated with Welborn

hospital for 10 years, then established his own office, specializing in anesthesia. Five years ago he re-entered private practice. Doctor Baker was a member of the Vanderburgh County Medical Society for many years.

Claudius C. Rayl, M. D., Decatur physician and surgeon for 33 years, died suddenly of a cerebral hemorrhage on January 1. Born in 1881, Doctor Rayl was a 1906 graduate of the Indiana Medical College, School of Medicine, Purdue University, Indianapolis, and did some postgraduate work at the Berlin, Germany, College of Surgery in 1913. Doctor Rayl practiced briefly in Berne and Monroe before establishing permanent practice in Decatur. He served as secretary of the Adams County Medical Society in 1911, 1912, 1913, and 1920, was an active member for many years in his county society, and a member of the Indiana State and American Medical Associations.

Charles E. McKee, M.D., 86, a general practitioner in Dublin for more than 50 years, died January 10 in the Henry County hospital, New Castle, where he had been hospitalized since last June. Doctor McKee was graduated in 1899 from the Eclectic Medical College, Cincinnati. He had been retired for several years, spending his winters in Orlando, Florida, and returning to Dublin in the summer. He was a senior member of the Wayne-Union County Medical Society, a Fifty Year club member of the Indiana State Medical Association and belonged to the American Medical Association.

Paul A. Garber, M.D., South Whitley, died on December 23 in an Indianapolis hospital where he was taken after suffering a cerebral hemorrhage a few days earlier. Doctor Garber had been in practice for 37 years. He was 60 years old. A native of North Manchester, Doctor Garber was a 1915 graduate of Indiana University School of Medicine and a veteran of World War I. Upon his return from service, Doctor Garber practiced for several years in Sidney, then went to South Whitley in 1927. He had served the Whitley County Medical society as secretary in 1926, 1931, 1932, 1935 and 1945; had served on a number of committees in the Indiana State Medical Association and had been 12th District Councilor. He was a member of the American Medical Association.

Robert J. D. Peters, M.D., 64, died January 7 in his Indianapolis home. Ill health had restricted his practice to office calls recently. A native of Macy, and son and grandson of physicians, Doctor Peters completed his medical education in 1915 at the Indiana University School of Medicine, served as an officer in the Medical Corps in World War I, and had practiced in Indianapolis since 1916. He specialized in internal medicine. Doctor Peters was a member of Indianapolis Medical Society, the Indiana State and American Medical Associations.



A.M.A. WASHINGTON OFFICE NEWS**THE MAGNUSON COMMISSION PROPOSES:**

**U. S. Subsidies for Prepaid Plans
Expansion of Group Practice
Expansion of Hospital Program**

**Aid to Medical Education
Department of Health and Security
Billion More Yearly for Health**

The report of the President's Commission on the Health Needs of the Nation recommends that the federal government take the lead in bringing about a series of momentous changes that would affect virtually every phase of medical activity. The cost would be about \$1 billion more annually, which the Commission says the country cannot afford not to spend.

The Commission, under chairmanship of Dr. Paul Magnuson, has been surveying medical problems for the last year. It was appointed by President Truman and expires on December 29. President-Elect Eisenhower up to now has not indicated his attitude toward the Commission.

Made public in December was the first volume, containing all recommendations. The remaining four volumes, devoted to details and statistics, are not yet ready for release. Following are more important findings and recommendations:

**Ask Cabinet-Rank Department
Of Health and Security**

The Commission decided that the interrelationship between federal health functions and general security functions "... is so fundamental that it indicated the desirability of combining" them. (Commissioners Evarts A. Graham and Russell V. Lee dissented, urging instead a cabinet Department of Health. Commissioner Joseph C. Hinsey advised more study.)

Also at the top level would be a permanent Federal Health Commission, similar to the Magnuson Commission, whose duty it would be to observe and report annually on all national health matters. It would contain no U. S. or state employees and not more than half of its members could be professional persons.

The tentative budget sets aside \$1 million to finance the Commission and federal programs for industrial health and migrant workers, but does not give a breakdown of costs for the three operations.

**U. S. Would Subsidize Prepayment Plans,
Operating Through State Agencies**

The Commission accepts the present prepayment plans as the most feasible vehicle for

eventually bringing comprehensive medical protection to almost everyone. The report reviews other suggestions in this area (Ives, Hill bills, etc.), then makes a new proposal. The administrative mechanism would be a federal-state program under which a single state health authority would draw up an overall state plan for using all available services and facilities, operating through local or regional health service authorities. The local prepayment plan would be the basic financing unit.

Each state's share of the federal funds—to be matched by the states—would depend on the state's income, with the poorest states receiving the largest per capita grants. An annual federal appropriation of \$750 million is proposed for this particular purpose. Federal funds, administered by a unit of the new Department of Health, would flow to the states, thence to the local level, and be used (a) to pay premiums for welfare cases, (b) to promote and extend prepayment coverage to the general public, subsidizing low-income groups where necessary, and (c) to operate facilities for long-range illness, available to all without a means test. To further encourage prepayment plans to extend coverage and liberalize benefits, the ban would be lifted on payroll deductions from U. S. employees, and OASI funds would be used to pay premiums for OASI beneficiaries. Eventually, care of veterans, merchant seamen and other federal

charges would be absorbed by the state and local systems.

Group Practice, More Attention to G. P.'s, Aid to Local Units Advocated

On medical service organization, the Commission expresses its findings as follows: "The genius for organization, so characteristic of American life in general, is conspicuous in health services by its absence . . . the lack of organization that prevails in medical practice is the despair of the industrialist and the labor leader." The report recommends:

For General Physicians—Their education, training and economic status should be studied and redefined; ways must be found to extend hospital affiliation to them or both doctor and patient will suffer.

For Specialists—Much greater emphasis on group practice. The report states: "We believe fundamentally that group practice offers a desirable method of providing medical services, properly organized and administered, so as to avoid the exploitation of one physician by another or by controlling hierarchy, and geared toward practicing the highest quality of medicine."

Coordination—Regional grouping of health services is suggested for sparse areas, with maximum cooperative use made of all available personnel and facilities. Federal loans are proposed to local organizations for establishing prepayment plans in which group practice would be utilized. A federal expenditure of \$10 million annually is suggested to cover costs of these two activities.

Public Health—Federal grants totaling \$60 million annually are proposed to help in establishing, maintaining and expanding the operations of local public health departments; present categorical federal grants would be increased and new ones authorized as problems arise.

Hospitals Would Function as Health Rehabilitation Centers for Community

The Commission advises extension of the Hill-Burton hospital construction program beyond its 1955 expiration date; also, annual appropriation to HB of \$150 million, in contrast to current

\$75 million. In the HB program, more attention should be paid to construction of health centers and special facilities for mental, chronic and tuberculosis care and for rehabilitation and research projects.

Establishment of medical centers in hospitals is strongly advocated. The report says: "The hospital of tomorrow should be a well-rounded health center from which preventive, diagnostic treatment, rehabilitation and home care services radiate to the entire community. It should be the center of the physician's professional life, providing laboratory and x-ray facilities for his use. . . . In the interests of preserving and increasing our national health we can and should be satisfied with nothing less."

Facilities described above, plus group practice clinics, would form a nation-wide network, largely sustained by prepayment insurance underwritten by the U. S.

Federal Support of Medical Schools Recommended by Committee

The report is uncompromising on personnel shortages. It concludes: "There are not enough general physicians . . . pediatricians . . . faculty members . . . specialists of all types with possible exception of surgeons . . . mental and tuberculosis hospitals are critically short of staff . . . growth of prepayment plans and extension of preventive medicine will increase the demand for physicians. . . . No matter what is done, we expect continuing shortages in the next few years."

The Commission proposes \$100 million annually in federal grants to medical and allied schools almost without restriction as to purpose. Money could be used to meet deficits, to purchase equipment, for modernization, for maintenance and for improving curricula. However, there would be these restraints on the federal government: "There must be no federal control over the curriculum or administration of any school, or the admission of applicants, except as may be necessary to maintain minimum standards."

No attempt is made to hold states and local communities responsible for maintaining medical

schools, nor are these non-federal sources called upon to increase their contributions in view of the medical schools' fiscal difficulties. There is this statement: "... any federal grants should supplement, not replace, state appropriations and private gifts, and should not exceed a designated percentage of a school's total operating budget. Federal scholarships also would be made available to qualified needy students."

Care of Military Dependents Questioned; Congress Asked to Rule on VA Problems

The Commission recognized the complaints of the medical profession against drafting of physicians to care for dependents of military personnel; the report suggests that if Congress decides such care is a military responsibility, it might be furnished through prepaid health policies. Congress is also urged to establish a clear-cut policy on the medical care of veterans by Veterans Administration. In its absence, the Commissioners decline to make any firm recommendations regarding the government's responsibility to care for veterans whose illnesses and injuries are not service-connected.

Additional Recommendations: \$20 million more is proposed for federal research and research grants programs. Development of improved methods of measuring morbidity at the federal level is recommended. Also discussed are problems in virtually every medical field, with recommendations made in most instances.

Social Security Amendments

During the past several years Congress has been pressured repeatedly to add some form of disability insurance benefits to the social security program. In 1949 suggestions for waiver of OASI premiums for disabled workers and money payments to those totally and permanently disabled were approved by the House of Representatives. But in 1950 the Senate dropped these provisions in passing the bill that finally became law.

In last session's social security amendments, the question of *waiver of OASI premiums for the permanently and totally disabled* was a center of controversy. AMA did not oppose the extension of any of the benefits, but it did object vigorously to provisions of the proposed law which would allow the Federal Security Admin-

istrator to prescribe regulations for medical determination of total and permanent disability. The House finally passed the bill with the controversial section on waiver of premiums included, after first voting against it. But the bill as passed by the Senate eliminated this section. In conference committee, a novel agreement was reached. A disability section written to expire June 30, 1953, was included in the law, but at the same time it was stipulated that claimants could not make application for benefits until July 1. Thus, the section would become inoperative the day prior to its effectiveness. In view of this situation, it is anticipated that the new Congress will hold public hearings on the waiver of premium issue soon after it convenes. There is, of course, the possibility that if Senator Taft's proposal for a commission prevails, the question will not come up and the section will be allowed to expire next June 30.

Also of importance (although no hearings were held on the subject last year) is the proposal for 60 days annual *free hospitalization for aged beneficiaries of the social security program*. We may confidently expect this proposal to be pushed again this year. Eligible persons are estimated at 7,100,000 and FSA has set the cost at about \$235 million a year. An informal opinion we obtained from insurance sources estimates it much higher.

Socialized Medicine Via ILO

A joint resolution, co-sponsored by 59 Senators and referred to as the Bricker Resolution, was introduced in the last session, providing for a constitutional amendment that would prohibit U. S. participation in any international agreement affecting the rights of American citizens or superseding the U. S. Constitution. Immediate target is the *International Labor Organization* which has proposed setting up minimum standards of social security, including national health insurance, through the avenue of a convention, which has the same force as a treaty. In other words, the affirmative vote of two-thirds of members of the Senate present would make it the law of the land. The AMA at its December Clinical Session in Denver reaffirmed support of the joint resolution. It is expected that the Senate will act on this matter in the new Congress.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE EXECUTIVE COMMITTEE

December 14, 1952

Roll call showed the following present: C. J. Clark, M.D., chairman; W. L. Portteus, M.D.; Paul D. Crimm, M.D.; W. H. Howard, M.D.; Wemple Dodds, M.D.; Roy V. Myers, M.D.

Albert Stump, attorney; James A. Waggener, executive secretary; Robert J. Amick, field secretary.

Membership Report

Number of members December 12, 1952...3,756*

Number of members December 12, 1951...3,676

Gain over last year ----- 80

* Includes 78 in military service (gratis)

138 \$10.00 members (residents and interns and new members after October 1)

252 senior members

1 honorary member

62 members, dues remitted by Council

Headquarters Office

Employment of a field man for the northern part of the state was discussed and the secretary was instructed to have the details worked out for presentation at the January meeting.

Letter from Dr. George F. Lull, secretary and general manager of the American Medical Association, in reply to a letter from the Executive Committee through the headquarters office, was read.

Statements of receipts and expenditures and report on the budget for October and November for the association and THE JOURNAL were approved.

1953 Annual Session, French Lick, October 19, 20 and 21, 1953

Upon motion of Drs. Dodds and Crimm an honorarium of \$100 is to be paid outstate speakers, and transportation and hotel expenses in addition. It was understood this commitment is to be made only in cases when such payment will be necessary to secure speakers.

Organization Matters

On motion of Drs. Portteus and Dodds, Dr. Cleon A. Nafe was elected as an alternate delegate for Dr. Homer G. Hamer for the balance of the term expiring December 31, 1952.

Letter from Inland Steel Company requesting 22,500 copies of the pamphlet, "Getting Well at Home," was read and the secretary was instructed to have an additional 50,000 printed so that the

request might be filled, on motion of Drs. Dodds and Portteus.

Resolution of Indianapolis Medical Society concerning Public Law 779 was read, and upon motion of Drs. Portteus and Myers the same was referred to the Council for action.

The secretary discussed the proposal to survey membership to determine the type of practice the members are currently engaged in and this was approved on motion of Drs. Dodds and Portteus.

The secretary discussed the revamping of the application form for membership in the state society and this was approved upon motion of Drs. Dodds and Myers.

Report of the Medical Exhibitors Association was reviewed by the committee.

The Journal

Report on advertising was approved by consent:

Total, December, 1951 ----- \$2,096.79

Total, December, 1952 ----- \$2,187.28

4th Quarter totals:

1951 ---- \$7,255.76 1952 ---- \$7,194.40

Future Meetings

The invitation to attend the closed session of the Council on Medical Service of the AMA at Chicago, January 21, 1953, was read and by consent the committee instructed Dr. E. S. Jones, chairman of Committee on Industrial Health, to attend this meeting.

By consent the president and executive secretary were given permission to attend the 49th Annual Congress on Medical Education and Licensure on February 9 and 10 in Chicago.

By consent Dr. J. E. Dudding, chairman of the Committee on Rural Health, and the secretary were given permission to attend the 8th Annual Rural Health Conference in Roanoke, Virginia, on February 27 and 28.

The committee adjourned to executive session.

There being no further business the committee adjourned to meet again at 6:15 p.m., Saturday, January 24, 1953, at the Athenaeum, Indianapolis.

LOCAL SOCIETY REPORTS

Dr. Danely P. Slaughter, assistant professor of surgery and radiology at the University of Illinois College of Medicine, was the speaker at the January 6 dinner meeting of the **Allen County Medical Society** in the Chamber of Commerce. He spoke to 52 members of the society on "Treatment of Inter-Oral Cancer."



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VESTIBULAR DYSFUNCTION associated with
- streptomycin therapy

VERTIGO in

Ménière's syndrome
hypertensive disease
fenestration procedures
labyrinthitis
radiation sickness



SEARLE Research in the Service of Medicine

Albert Stump, Indianapolis, counsel for the Indiana State Medical Association, was the guest speaker at the December 18 meeting of the **Camp Atterbury Medical Society**. The January 15 meeting at Camp Atterbury was addressed by Captain Auerban who spoke on "Interesting Cases of Vascular Abnormalities." Refreshments were served in the Officers' Club following both meetings.

A telephone seminar and election of officers comprised the program when members of **Boone County Medical Society** met January 7 in Witham Memorial hospital, Lebanon.

Eight members of the **Clay County Medical Society** met for a 6:30 dinner and election of officers in the Elks Club in Brazil on December 16.

Business of the local society with reference to the local T. B. Association program and drafting of a resolution on the death of Dr. A. Golding Chittick were discussed at the January 6 meeting of the **Clinton County Medical Society** in the Clinton County hospital. Thirteen members enjoyed a 6:30 dinner preceding the business meeting.

The film "Without Fear" was shown to eight members of the **Dearborn-Ohio County Medical Society** at their dinner meeting on December 18 in the Dearborn Country Club at Lawrenceburg. Election of officers followed the showing of the film.

Floyd and Clark County Medical Societies and their auxiliaries held a joint dinner meeting December 10 in the New Albany Country Club. A welcome was extended by Mrs. Margaret Goodman, Clark County Auxiliary president, who then turned the meeting over to Dr. Eli Goodman, president of the county society, who introduced Robert J. Amick, ISMA field representative and read a letter of thanks from Congressman-elect Bailey Merrill who expressed appreciation to all doctors and their wives for their efforts in his behalf and reminded them that their success gave the new administration one-third of the slim balance of three in the House of Representatives.

Dr. Howard W. Byrn, president of the **Floyd County Society**, reviewed his group's activities during the last year, saying he felt the best step forward had been made in relation to the adoption of a more suitable fee schedule by the County Welfare department. Dr. Goodman told of accomplishments in Clark county including a county-wide immunization program, establishment of a speakers' bureau, an exhibit of AMA material at the Jeffersonville Sesquicentennial, the adoption of a new Constitution and several other projects.

Dr. Crimm was introduced by Dr. William Garner, district councilor.

A talk on "Vitamins" was given by Jim DePree, Holland, Michigan, to 20 members of the **Gibson County Medical Society** on January 12 when they held a dinner meeting in the Emerson Hotel, Princeton.

Green County Medical Society met in the Freeman Greene Hospital in Linton for their December dinner meeting when they viewed the two films, "Without Fear" and "Backfire" and elected officers. Sixteen members attended.

Dr. John A. Hetherington, Indianapolis, was the guest speaker on January 13 at the dinner meeting of the **Hendricks County Medical Society** in Ment's Chicken House in Avon. He discussed "Head Injuries." The 11 members present also elected officers. The February 10 meeting will be held in the home of Dr. M. O. Scamahorn, Pittsboro.

Eight members of **Jay County Medical Society** heard a paper on "Urologic Complications of Pregnancy" given by Dr. Robert Peacock, Muncie, at their dinner meeting January 8 in the Portland Country Club.

Ten members of the **Jefferson-Switzerland County Medical Society** elected officers for 1953 and saw the film "Without Fear" at an evening meeting held in King's Daughters Hospital, Madison, December 15.

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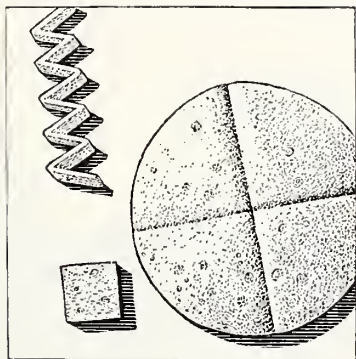
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Books

BIOLOGICAL ANTAGONISM, THE THEORY OF BIOLOGICAL RELATIVITY, by Gustav J. Martin, Sc. D., Research Director of The National Drug Company, Philadelphia. Cloth. \$8.50. Pp. 516 with 64 Figs., 44 Tables. Blakiston Company (Division of Doubleday and Company, Inc.), 1012 Walnut St., Philadelphia 5, 1951.

Research workers in immunology, pharmacology, chemotherapy, antibiotics, medicine and biology in

general will find this book a valuable reference. The author summarizes the present day knowledge, the areas of incompleteness, and the possible fields for future experimentation in the realm of structural displacement of metabolic analogues. He applies biological antagonism to the many fields as proteins and amino acids, anti-metabolites of vitamins, purines and pyrimidines, steroids and lipids, minerals, etc. Individual chapters deal with experimental data, each being a compilation of the work that has been done in that specific area. A concluding section of each chapter is termed, "comment." Here outstanding concepts are recapitulated in terms devoid of technical data to develop the author's theory of biological relativity. An overall bibliography of more than 1900 references shows that the author has comprehensively surveyed the literature and has based his theoretical presentation only after considerable study.

Much attention is given to the kinetics of enzymes, the alteration of which the author considers to be the mechanism of action in displacement compounds. He believes that "relative enzyme concentrations will form the core of future medical science; that they will determine selective toxicity phenomena; they will under-lie selective pharmacological and chemotherapeutic activity." Synthetic antagonists are viewed as those of prime concern here, whereas natural antagonists are those of prime concern in physiology, biochemistry and immunology.

At first glance the general practitioner of medicine might lay this book aside as being presented only for followers of research. As he thumbs through the pages, however, he is challenged to understand the facts about many substances with which he is concerned daily and about which he should be reasonably informed.

The author closes his study of antagonism with a philosophical chapter on biological relativity. He concludes that there are no absolutes in biological systems which might distinguish them from physical systems. Every phase of biology is relative; there being no absolutes beyond time. Biological antagonism is viewed as a manifestation of competition between moieties for surface position on proteins. All the processes of life are fundamentally enzymatic in character; the enzyme is the universal living element.

This is not a book to be read; it must be studied.

T.M.C.

LOCAL SOCIETY REPORTS

LaGrange County Medical Society held an election of officers at a noon meeting in LaGrange County Hospital, December 17. All nine members of the society attended.

The Christmas party of the LaPorte County Medical Society which was held December 18 at Welker's Farm restaurant was attended by 96 doctors and guests. Election of officers was followed by an informal program.

William L. McGrath, Cincinnati, gave a report on the 1952 ILO Conference in Geneva, Switzerland, to 68 members of the Madison County Medical Society December 15. The meeting was held in the Delco-Remy cafeteria and election of officers followed the address.

Fifteen members of Putnam County Medical Society viewed a film furnished by state headquarters and elected officers at a meeting held December 12 in the Union Building on the DePauw campus, Greencastle.

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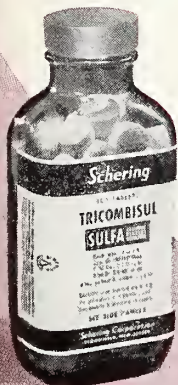


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11.	Richard P. Good, Kokomo.....	C. R. Herd, M.D., Peru.....	Delphi, May 20, 1953
12.	Wm. J. Gerding, M.D., Fort Wayne.....	James M. Burke, M.D., Decatur.....	
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Opinions From Here and There

**Prepared for your information by the Committee on Public Policy and
Legislation of the Indiana State Medical Association**

BUTTON, BUTTON, WHO'S GOT THE BUTTON?—might well be the slogan of the Indiana State Legislature. Everyone, including the members of the legislature, state they are confused and there is some basis for their feeling.

LARGEST NUMBER OF BILLS SINCE 1941 SESSION—at the close of time for introducing bills in this session a total of 535 bills had been placed in the hopper of the House and 338 bills had been introduced in the Senate for a grand total of 873. The majority of them would not have been missed if they had never been introduced.

47 BILLS TOUCH THE MEDICAL PROFESSION—many of them are insignificant but some may have far-reaching effect upon the profession. Opinions are divided on the reorganization bills, some think they go too far and tend to establish too much power in the hands of the Governor, while some believe they will bring about some necessary changes. Physicians should be especially interested in Senate Bills 115 and 205, and House Bills 259 and 421.

A.M.A. OFFICIALS VISIT THE PRESIDENT AND FSA ADMINISTRATOR—

A committee appointed by the AMA's Board of Trustees visited for 45 minutes, February 5, with President Eisenhower in a "get acquainted" meeting and general discussion of health problems. AMA President Louis H. Bauer said the White House conversations were friendly and helpful although "merely exploratory." Accompanying Dr. Bauer were President-elect E. J. McCormick, Dr. Dwight Murray, chairman of the Board, and

Dr. Frank E. Wilson, director of AMA's Washington office. Also present were FSA Administrator Oveta Culp Hobby and Major-General Wilton B. Persons, special assistant to the President for legislative liaison.

GROUP MEETS WITH OTHERS IN WASHINGTON, in addition to the above Dr. F. J. L. Blasingame, chairman of the Board's Committee on Legislation, Dr. George F. Lull, secretary and general manager of the AMA, and Dr. Ernest B. Howard, assistant secretary, conferred with Oveta Culp Hobby, FSA administrator, and Surgeon-General Leonard A. Scheele of the U. S. Public Health Service. Members of the delegation commented upon the friendly reception from Mrs. Hobby and said several health problems were discussed, but that no one made a specific suggestion.

MRS. HOBBY EXPRESSES VIEWS IN FIRST ADDRESS as Federal Security Administrator. Talking before a group of Republican women, Mrs. Hobby said, "To junk at once all that came to us from the preceding administration would be unfair . . . we must not start with any idea that the policy can be changed overnight."

PRESIDENT EISENHOWER EXPRESSES HIS VIEWS on several matters of importance in his State of the Union message. Included were: 1. Commission and FSA Reorganization—"Health and housing needs of our people call for intelligently planned programs. Involved, too, are the intricate matters of achieving proper federal, state, and local relationships; assuring the solvency of the whole security system; and guarding against its exploitation. To bring purpose and orderly procedure into this whole field, I anticipate a thorough study by an appropriate commission of the proper relationship among federal, state, and local programs in this whole field. I shall shortly send you (Congress) specific recommendations for establishing such a commission, together with a reorganization plan defining new administrative status for all federal activities in the field of health, education and social security."

REED-KEOGH AND SOCIAL SECURITY—"Provisions of the Old Age and Survivors Insurance Law should promptly be extended to cover millions of citizens who have been left out of the Social Security system. No less important is the encouragement of privately-sponsored pension plans."

The "privately-sponsored" pension plans apparently would include the Reed-Keogh principle for deferment of income taxes, a proposal previously endorsed by the President.

OTHER RECOMMENDATIONS OF THE PRESIDENT INCLUDE: The President called attention to the country's traditional generosity in caring for disabled . . . and the widow and orphan of the fallen. He did not, however, touch on such controversial issues as care of the non-service cases or problems of Veterans Administration's medical department . . . President Eisenhower asked Congress to act promptly to give the Food and Drug Administration authority to make surprise inspections of factories, which a December Supreme Court ruling said FDA could not continue to do under existing law . . . He reaffirmed the federal government's role in civil defense as one of furnishing leadership and technical guidance and of building up medical and other emergency stockpiles.

ADMIRAL BOONE DEPLORES "SEGMENT OF MEDICINE" OPPOSED TO VA. Vice Admiral Joel T. Boone, medical chief of the Veterans Administration, is convinced that a segment of medicine is so determined to eliminate non-service connected disability care that it would, in the process, destroy the entire VA medical program. In testimony before the House Veterans Affairs Committee, Admiral Boone declared "we were able to defeat" in the AMA House of Delegates last December a resolution which he claimed would have "destroyed our program." He added that it was "inconceivable that anyone, in or out of the profession," would take such steps.

THE RESOLUTION OBVIOUSLY WAS THAT PROPOSED by the Special Committee on Federal Medical Services; it included a proposal that non-service disabilities be limited to care for tuberculosis and psychiatric and neurological disorders. Admiral Boone stated there was "not much difference between non-service and service connected disabilities."

BILL WOULD ADD APPROXIMATELY 25,000 NEW BEDS to present VA facilities. H.R. 2001, introduced by Rhodes (D) of Penn., would authorize the VA administrator with the approval of the President to construct facilities adding approximately 25,000 beds.

U. S. LOSS OF MILLIONS ON AID PAYMENTS REPORTED. The federal government loses perhaps as much as \$75 million annually in payments to ineligible kept on state rolls of needy aged, dependent children, the blind and totally disabled (U. S. shares cost with states). This was the estimate of a Senate investigator who spent months looking into Federal Security Agency's Bureau of Public Assistance. The investigator testified at a hearing of the Senate Investigations Subcommittee that the Bureau couldn't detect more than a portion of the ineligible because it had only 33 trained technicians checking up on the whole country.

PRIORITY III PHYSICIANS FACE EXAMINATION according to Washington Report. The report states that in sending out the March call-up instructions Selective Service headquarters informed state draft directors they may begin tapping III's who have not reached thirty-sixth birthday. Same policy has prevailed for Dentists in III for past several months.

COMPLAINTS ON INCREASE AGAINST ANY AMENDMENT TO PUBLIC LAW 779, the doctor-draft law. A mounting volume of protests against providing an escape hatch for non-veterans while other physicians stood in the shadow of a recall to military duty are being received in national headquarters. Many of the correspondents, too, express bitterness on working of local draft boards.

IN A CLOSED SESSION OF HOUSE INTERSTATE COMMITTEE, Rep. Paul F. Schenck (R., Ohio) raised point whether it would not be logical for that Congressional unit—overseer of national health matters—to consult with and advise its sister Armed Services Committee when latter gets around to consideration of PL 779 amendments in near future. The second-term Congressman, whose logic was quite sound, was set down with the reminder that things aren't done that way on Capitol Hill, where each committee is jealous of its autonomy.

NEARLY 1,000 4-F'S, PHYSICIANS AND DENTISTS who are in priorities I and II have been ordered up for re-examination, with another batch of names to be submitted later for the same purpose. Army fell far short of making its dental goal in December and it is estimated that January procurement will show a deficit of 370 physicians and 310 dentists.

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TRAUMATIC RUPTURE OF DIAPHRAGM

Case Report and Discussion

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Indianapolis

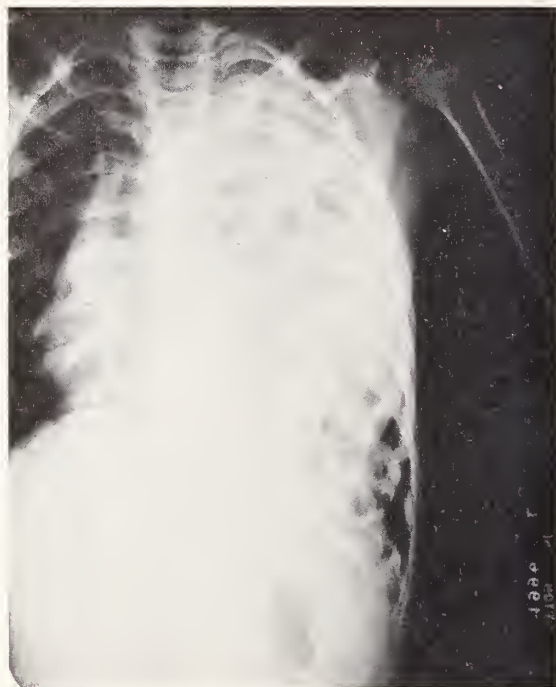
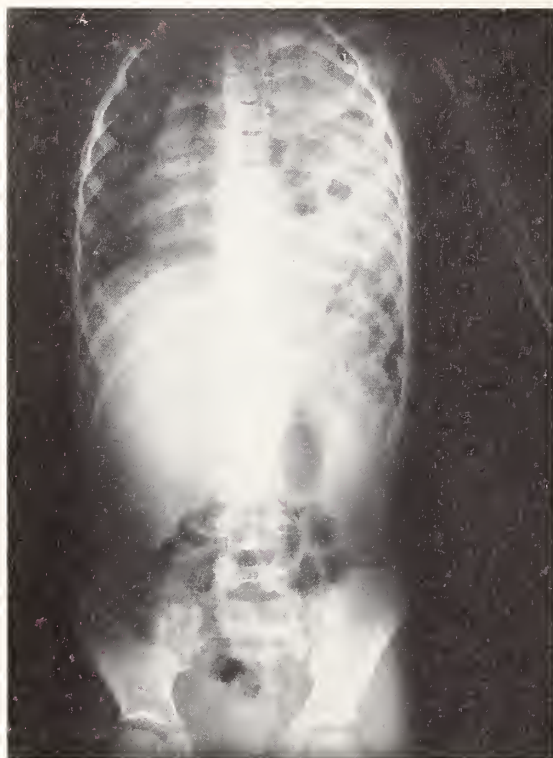
Case Report

J. S., white male, age 5, was admitted to the St. Vincent's Hospital on 8-8-52. Three days previously he had been pinned beneath an overturned tractor on which he and his brother had been riding. The metal gas line of this tractor had penetrated his left arm. He suffered lacerations of the head, right leg and anterior abdominal wall. He was not unconscious. There was no marked dyspnea. Management elsewhere consisted of repair of lacerations, sulfonamide medication, X-rays and careful observation. He seemed to improve, and took some soft food by mouth. He did not vomit. There was no blood in his stool or urine; he did not have hemoptysis. The diagnosis of traumatic rupture of the diaphragm was made and on the third day he was transferred to us for definitive surgery. On admission here he appeared acutely ill, somewhat dyspneic and faintly cyanotic. Respirations were 30 to 40, pulse 140. Temperature was 100 rectally. Breath sounds were normal in the right chest. On the left they could be heard faintly posteriorly. One examiner heard thoracic bowel sounds. The abdomen was scaphoid. It was soft and silent. The remainder of the physical examina-

tion showed the sutured lacerations already described, but no other abnormal findings. Laboratory findings were as follows: hemoglobin 8.35 grams per cent. Erythrocytes 3.33 million per cubic millimeter. Leukocytes 6,600 per cubic millimeter with 1 juvenile cell, 9 band cells, 54 segmented polys, 32 lymphocytes and 4 eosinophils. Urine was normal except for crystals of sulfaguanidine and sulfathiazole. The x-ray disclosed a rupture of the left diaphragm with intrathoracic bowel and complete atelectasis of the left lung. There was a moderate amount of mediastinal shift to the right. (Figs. 1 and 2.)

Management

A blood transfusion was begun, a Levine tube was anchored and Wangenstein suction begun. The suction yielded a small amount of brownish fluid. The child was given one-half gram of streptomycin, 100,000 units of aqueous penicillin, 1 cc of aqueous procaine penicillin (Wycilin) and atropine sulfate grains 1/300. He was taken to surgery and prepared for thoracotomy. Anesthesia was endotracheal with cyclopropane induction and ether maintenance. A standard thoracotomy incision was employed, modified in that it extended slightly more anteriorly and



Figs. 1 and 2—Chest films taken before surgery revealing rupture of the diaphragm with intrathoracic bowel and complete atelectasis of the left lung.

slightly less posteriorly than usual. The seventh rib was resected. As the pleura was opened small bowel, transverse colon and omentum were encountered. Atelectasis of the left lung was complete. The bowel was dilated although there was no evidence of impaired blood supply. Reduction was accomplished after the rent in the diaphragm was enlarged. The original rent was anterior and extended from 4 cm medial to the periphery of the diaphragm to the esophageal hiatus. The hiatus was only partially involved. The mediastinal pleura was torn. The spleen was carefully examined and was found to be uninjured. Repair was accomplished with a row of figure eight sutures reinforced with a row of Lembert sutures. Zero silk with an atraumatic needle was employed. The phrenic nerve, near the diaphragm, was lightly crushed with a small hemostat. An endothoracic catheter was inserted through a stab wound. 100,000 units of penicillin were introduced into the thoracic cavity and the lung inflated. The chest was closed in layers using 0 chromic catgut. The catheter was connected to a water seal.

Post-operative course

Gastric suction was continued for 24 hours. The patient was given $\frac{1}{2}$ cc of procaine penicillin and 250 milligrams of dihydrostreptomycin every 12 hours. Good breath sounds were heard bilaterally at the conclusion of the operative procedure. A chest plate taken the following morning revealed complete expansion of the left lung. (Fig. 3.) Accordingly, the endothoracic catheter was removed. Convalescence was completely uneventful. Temperature was 102 (rectal) on the first postoperative day. It was 99.4 (rectal) on the second postoperative day, and remained normal thereafter. Antibiotics were discontinued on the sixth postoperative day, and a final chest film taken. (Fig. 4.) Sutures were removed and the patient discharged on the seventh postoperative day.

Classification

Traumatic diaphragmatic hernias are said to be direct if they result from dissolution of diaphragmatic substance due to a knife, bullet or



Fig. 3—Film taken first postoperative day revealing complete expansion of the left lung and correction of diaphragmatic hernia.

some other wounding object. They are called indirect if they result from a crushing abdominal injury. Sometimes discussed with traumatic ruptures are cases wherein the rupture results from a septic process such as a subdiaphragmatic abscess. Harrington states rupture has been caused by a tube left in the thoracic cavity for drainage of an empyema⁴ and Berman reports a similar experience with a drain used in a perinephric abscess.²⁰

Discussion

Rupture of the diaphragm can occur at virtually any point. There is no higher incidence of rupture at the "weak spots"—the points of embryological fusion. Statistically, however, approximately 95 per cent of all traumatic ruptures are left-sided. On the right side the liver offers protection. It is of interest to note that 90 per cent of all strangulated diaphragmatic hernias are traumatic in origin^{1, 12}. To be sure, many of these strangulations occur in the quiescent period (that period well removed from the traumatic incident in which there are few symptoms). Symptoms that may be present at this time are mild epigastric pain with radiation

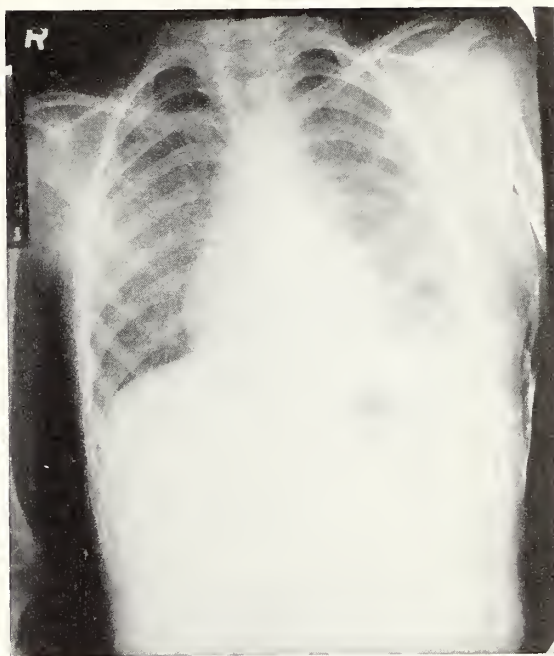


Fig. 4—Film taken sixth postoperative day revealing complete expansion of left lung and no free fluid.

to the left shoulder, bloating and belching. Repair is indicated even in the case in which these symptoms do not exist, for there is always danger of strangulation. This propensity for diaphragmatic hernias of traumatic origin to cause strangulation is explained on the basis of the usually small hernial ring present and thus the greater chance for impairment of visceral blood supply. As for the acute case, early exploration is uniformly urged^{11, 1, 20}. Delay may bring circulatory collapse from mediastinal shift, pneumonia from atelectasis, strangulation of bowel or stomach, and in the very late cases, adhesions between the herniated viscera and cut edge of the diaphragm. It is cautioned, however, that the definitive repair must certainly be deferred in instances of extensive associated injury until the patient's condition is stabilized. To put the same proposition more positively, experience has shown that splenectomy can safely be done trans-thoracically at the time of the repair in most instances, but one would hesitate to couple his diaphragmatic repair with any formidable amount of intraabdominal surgery. The spleen is always carefully inspected at the time of surgery even though there is no obvious splenic bleeding, for the occurrence of subcapsular hematoma with delayed rupture is always borne in mind. In most cases there is no difficulty in having enough tissue available for repair. When

there is insufficient tissue, the attachments of the diaphragm are mobilized posterolaterally and are reattached higher up—to the seventh or eighth ribs^{3, 13}. An alternative procedure is to mobilize the chest wall so that the edges of the tear can be sutured together without tension. This is accomplished by resecting a few inches of the eighth, ninth and tenth ribs.²⁰ As for the practice of routine phrenemphraxis, the reader is referred to the excellent review by F. Hughes.¹³ He reports 28 cases of traumatic rupture of the diaphragm and he has only one recurrence. This case developed a severe coughing paroxysm shortly after surgery and at this time rupture recurred. Phrenemphraxis would probably have prevented this, and is now invariably performed. The case for routine closed drainage of the chest is less convincing. We are agreed that in most instances it is probably not necessary, but certainly an intrathoracic catheter left in place for a day or two does no harm. Complications following surgery, in addition to recurrence, are pleural effusion (usually transient), pneumothorax and empyema.

Summary

1. A case of traumatic rupture of the diaphragm in a 5-year-old child is presented.
2. Traumatic diaphragmatic hernias are direct, indirect or secondary to an inflammatory process.
3. Ninety per cent of all strangulated diaphragmatic hernias are found in hernias of traumatic origin.
4. Surgical correction is indicated as soon as the patient's condition permits.

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Red Cross Nurses

A monthly average of 4550 nurses gave voluntary service to their communities through the Red Cross during the 1951-52 fiscal year. These nurses served during disasters and epidemics, helped in clinics and blood centers, and issued 255,000 certificates to people who completed home nursing courses.

A CASE OF ABDOMINAL PREGNANCY

R. O. WHARTON, M.D.

Gary

I AM REPORTING a case of abdominal pregnancy. I have delayed several years in doing it because many authorities think abnormalities may show up after a period of time due to this type of pregnancy.

Obstetrical History:

The mother had given birth to a girl who was 14 years of age and a boy who was six years of age prior to the birth of this baby. Each pregnancy and labor was normal and each child was normal in every respect. Postpartum examinations showed the uterus to be slightly larger than the average size and the adnexa appeared entirely normal.

Gynecological History:

Menstruation came every 28 days, the flow lasting 4 or 5 days. There was nothing about the mother's history such as dysmenorrhea or menorrhagia that would suggest the slightest etiological factor relative to extra-uterine pregnancy.

History of Pregnancy:

Mrs. F. F., a 30-year-old white multipara, came to my office June 14, 1945. Her last menstruation started April 21, 1945. She complained of considerable soreness about the nipples and of extreme nausea. Vaginal examination showed the cervix to be soft, and the fundus enlarged to about the size of a seven weeks' pregnancy. No adnexal tenderness or masses could be detected. Hexabetalin relieved her nausea. The estimated date of confinement was January 28, 1946.

Starting July 3, she noted a slight pinkish vaginal discharge which continued two or three days. On August 30 I was called to the home because she was having abdominal pain. Examination showed rather severe tenderness over the region of the left adnexa, less over the right. She had slight tenderness in the midline extending from two inches above the navel to two inches below it. A pelvic tumor mass appeared

about the size of a normal four-month pregnancy. Her general condition was good. A single dose of dilaudid gr 1/20 hypo gave relief.

At times later on she had slight abdominal pain, which was relieved by Empirin compound No. 3.

At routine examination on February 10, 1946, a slight vaginal bleeding was noted.

The baby was in transverse position, its head was to the mother's right, its buttocks to the left, and its back toward the pelvis. Rectal examination showed a boggy mass between the examining finger and the foetus, leading to a diagnosis of placenta previa centralis. No other abnormal findings could be detected prior to surgery.

Treatment:

The patient entered Methodist Hospital and a Cesarean section was performed February 11, 1946. The usual midline incision was made. Something abnormal was first observed when large varicose blood vessels were seen through the peritoneum: but even after opening the peritoneum, the baby could not be seen. On cutting through what appeared to be thin uterine wall it was found to be placenta and very thick amniotic and chorionic membranes. An average amount of amniotic fluid was in the sac. The baby was easily lifted out.

An extremely careful study of the pelvic mass was necessary to determine its true nature and attachments. The placenta was found to be a bilobular structure with central origin from the greatly thickened upper margin of the left broad ligament.

The broad ligament was about 1 c.m. wide and was of about the same consistency as a uterine fibroid. The smaller lobe of the placenta was about 8 c.m. in diameter and varied from 2 to 3.5 c.m. in thickness. It extended posteriorly from the broad ligament into the cul-de-sac. The larger lobe of the placenta was nearly 14 c.m. in diameter and was about the same

thickness as the smaller lobe. It extended anteriorly and upward along the abdominal wall. The membranes were about 2 mm. thick, extending out from the margins of the placenta as in a normal pregnancy. The cord and foetal side of the placenta appeared normal. The outer or maternal side was covered with membrane, smooth and shiny like the normal foetal side. The entire blood supply came from the greatly dilated ovarian and uterine arteries, entering through the placental attachments to the greatly thickened broad ligament. The fallopian tube and ovary each appeared normal. They were external to the amniotic sac and unattached to the placenta and membranes.

There was no evidence that there had at any time been a tubal or ovarian attachment of the placenta. There were a few adhesions; those between the membranes and the tip of the appendix, and those between the membranes and the omentum. Otherwise the sac and the placenta were entirely free from the uterus and the other abdominal structures. It was difficult to determine the dividing lines between the placenta, the dense broad ligament, and the uterus. The uterus itself was about 12 c.m. long, 7.5 c.m. wide, and 5 c.m. thick. It was slightly more soft than a non-pregnant uterus, otherwise it was normal.

There was practically no loss of blood after removing the baby. After ligating the adhesions, it was possible to apply clamps to the broad ligament and to remove the entire mass, including the left tube and ovary, in much the same way as in doing a normal salpingo-oophorectomy. No uterine tissue was removed, but the left tube and ovary were removed with the mass. Fearing endometriosis, the right ovary was also removed. The abdomen was closed in the routine way.

The Child:

The baby was a male, weighing 7 pounds and 8 ounces. He was resuscitated without difficulty and appeared normal in every respect, so one could not detect anything different from a normal intra-uterine child.

Postoperative Course:

The mother and the baby progressed in a

perfectly normal way, leaving the hospital on the tenth postoperative day.

Infancy and Childhood:

I have watched this mother and her baby very closely since its birth. His infancy and childhood were like that of a child of normal pregnancy and birth. He is now past 6 years of age; he has learned to walk and talk as any normal child. As he has become older, he plays and shows the mental progress of the average child of his age.

Abdominal Pregnancy:

A brief resume of medical history relative to abdominal pregnancy might well be in order.

Harnes reports from the files of the New York Lying-In Hospital, that ectopic pregnancy was found once in every 15,000 cases.

Hellman and Simon reviewed the literature, finding at that time a record of 316 cases. In 158 of these cases the child lived 8 or 9 days following birth. In 80 of these cases both the mother and child lived. In only 50 cases of those surviving they reported the mother and the baby as being completely normal. A large percent of the children showed some form of foetal deformity, which in most cases was due to the abnormal position and pressure in an abnormal way against organs and bony structures around the abdomen.

Beck searched the literature from 1809 to 1919 finding a living foetus in 262 cases of abdominal pregnancy upon which operation was performed after the fifth month of pregnancy. Of 244 cases in which dates were given, 49 lived one year. Most authorities hold that the child must reach two years of age with no evidence of abnormality before it can be considered normal.

Comments:

It has proven to be a most interesting experience to see such a rare complication of pregnancy. It is a complication in which very few mothers and babies maintain perfect health. The child is perfect both mentally and physically. Likewise the mother was able to endure this

very unusual type of pregnancy and to maintain her own normal health.

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Names Changed

The Archives of Physical Medicine has been renamed Archives of Physical Medicine and Rehabilitation. As the official journal of the American Congress of Physical Medicine and Rehabilitation (also renamed to replace the former American Congress of Physical Medicine) the Archives name change is timely and conforms with the section of the American Medical Association dealing with the selection of apparatus in this field of medicine. That section is now known as the Council on Physical Medicine and Rehabilitation.

CONGENITAL UMBILICAL HERNIA*

ELTON R. CLARKE, M.D.

Kokomo

CASES of congenital protrusion of abdominal viscera at the umbilicus may be divided into those of (1) umbilical hernia, which is covered with skin and is of most frequent occurrence, requiring little or no immediate attention, (2) herniation into the umbilical cord or funicular hernia, and (3) true omphalocele or amnio-coele. The last two require early surgical treatment if the infant is to have the best chance of survival. In order to avoid confusion in terminology, the word omphalocele should be reserved for the anomaly in which the defect is in the abdominal wall rather than in the umbilical ring.

Characteristically, in omphalocele there is protrusion of abdominal contents, covered by the peritoneum internally and amnion externally, involving the supra-umbilical part of the abdomen. If this defect is allowed to continue, drying of this membrane occurs within a short time with its rupture and inevitable peritonitis. Kahle¹² states that "Almost all of the abdominal contents have at times been found in an omphalocele, but the small intestine and portions of the liver are most frequently present."

Embryologists tell us that in the latter part of the second month, "the proximal end of the umbilical cord becomes considerably expanded, and into its extra-embryonic coelomic cavity extend several coils of the embryonic intestine and even a portion of the liver. This characteristic extension of the intestine (intestinal hernia) reaches its maximum during the second month. The intestine is rapidly withdrawn later and at about nine or ten weeks is completely retracted into the embryonic body cavity."¹ The development of the mid-gut is so rapid that a convex loop is thrown forward into the extra-embryonic coelom in the umbilical cord.

With such potential weakness, then, one might

expect a rather frequent occurrence of such defects. Such is not the case, however. A search of the literature reveals a relative paucity of such cases, and for this reason report is being made of two cases illustrating different types of anomalies attended by the author this year (1952), although previously he had not seen any such in about 2,000 deliveries. Jarcho²² cites the reported cases up to 1937, giving the incidence at about 1:6,600. Other writers quote from 1:5,000 up to 1:11,000.

Gross and Blodgett² reviewed 22 cases, of which two were not operated upon and died. Twenty were operated upon and 10 of these died. Prognostic factors of importance were the time of operation—earlier the better; the size of the sac, being poor in those of sacs of 8 cm. or more in diameter, and the contents of the sac, being much worse if the liver is included. Dr. Gross has outlined the surgical procedure developed by him of a two-stage operation, first cutting free and undermining the surrounding skin and then bringing together these huge cutaneous flaps anteriorly to cover the bulging omphalocele sac. Secondary repair is then done from six to twelve months later.⁴ Dangers of over-crowding of the viscera into the abdominal cavity are cited by Gross as respiratory embarrassment and cyanosis, obstruction of the venous circulation, and impaired function of the gastro-intestinal tract or even intestinal obstruction.

As is often true with other congenital anomalies, these lesions are apt to be associated with others, although not in these cases reported. Cleft palate, Meckel's diverticulum, volvulus, jejunal atresia, diaphragmatic hernia, urogenital defects, dextrocardia, cardiac extrophy and patent foramen ovale are some that are reported. For some reason developmental anomalies of the mid-gut seem to be more prone to be associated with other anomalies than are those of the fore-gut.

* A report of two cases of different types, with operative notes by Jesse S. Spangler, M.D., and John H. Alward, M.D.

Case 1. *Funicular hernia, or hernia into the cord.*

Mrs. J. W., white, Gr. 2, age 25, entered the hospital on the morning of April 11, 1952, with fairly good, steady contractions. She had been bleeding a little since the day before. Position of baby, ROP. Podalic version and extraction was done to effect delivery, which was difficult, but no pressure was made upon the baby's abdomen. The baby, a male weighing 10 lbs. 8 oz., was delivered and handed to a nurse, who placed him in a crib. While the perineum was being repaired and placenta delivered, the baby cried or coughed and forced out through the umbilicus a little pile or handful of small intestines. These were covered with sterile gauze, and a surgeon called at once. It had been noted at the time of delivery in tying off the cord that it was particularly large, being varicosed or velamentous in type and requiring double ligation.

Immediate operation was done under drop ether anesthesia, given by the same anesthetist that had been giving gas and ether to the mother for the podalic version. The abdominal contents were replaced, and the little patient made an uneventful recovery.

The mother's serology was negative, and the Rh-factor was positive.

Case 1. *Report of operation.*

Baby J. W., 30 min. old.

Pre-operative diagnosis: Rupture of navel, with evisceration through hernia of navel. Congenital anomaly.

Post-operative diagnosis: same.

Name of operation: Closure of defect, after replacing of contents into abdominal cavity.

Description of operation:

Normal saline to intestines—replacing of intestines into abdominal cavity. Excess of cord cut away; peritoneum closed with interrupted chromic catgut No. 0 sutures. Fascia closed with continuous chromic catgut No. 0 suture. Dermol for skin. Dressing.

Gross pathology:

Defect at navel with velamentous covering only of the defect, allowing intestines to rupture through defect, on right side, toward navel from site of ligation of cord. Small intestine (ileum), appendix, caecum, and ascending colon in mass. The defect is about $2\frac{1}{2}$ to 4 inches in diameter. Stimulants used: none.



Figure 1. Infant operated upon for funicular hernia (Case 1) as he appears five months after birth (and operation).

Drainage: none.

Anesthetic: Ether by drop method. (C. T. Dutchess, M.D.)

Jesse S. Spangler, M.D.
Surgeon

Post-operative care:

Breast feeding.

Dressings as needed.

Penicillin (Duracillin A.S. 150,000 units)
q. 12 hr.

Case 2. *Omphalocoele with intra-uterine eventration.*

Mrs. J. C., white, Gr. 3, age 31, entered the hospital on the morning of July 24, 1952 with contractions about five minutes apart and delivered at 4:44 P.M., CDT, placenta at 4:50 P.M. Blood loss estimated at 250 c.c. The delivery was with low forceps and uneventful, cephalic LOA. As delivery was being made, it was noticed that there was eventration of all of the small intestines, the caecum, appendix and the tip of the liver. A surgeon, Dr. John H. Alward, was called immediately, and preparations were made at once to put the organs back into the abdominal cavity. The intestines and mesentery were covered with a greenish fibrinous exudate, as though they had been out and bathed by the amniotic fluid for some time. Serology of the mother, negative.

The infant, a female, 4 lb. 15 oz. was about four weeks premature. She was placed in the Air-Lock incubator immediately after operation, but her condition was not good, and

she expired at 11:47 P.M., about 6½ hours after operation.

Case 2. Report of operation (7-24-52)

Baby C., less than 30 min. old.

Pre-operative diagnosis: Complete eventration (ruptured omphalocele).

Post-operative diagnosis: same.

Name of operation: Reduction of same and skin closure.

Description of operation:

Under no anesthesia, the intestines and stomach were emptied of meconium and gas via suction tube in mouth, and long upper and lower midline incisions were made from umbilicus. With great difficulty the viscera were replaced in the tiny abdominal cavity and subcutaneous sac created by wide undermining. Suture closure of heavy silkworm gut was used (interrupted).

Stimulants used: none.

Drainage: none.

John H. Alward, M.D.
Surgeon

Summary and conclusions:

1. Two cases are presented of similar conditions, one of congenital funicular umbilical hernia, and one of true omphalocele with intra-uterine rupture.

2. Emphasis is made upon the importance of early operation in these cases, within the first hour of life if this is at all possible.

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CHRONIC DIARRHEA-- DIAGNOSIS AND MANAGEMENT*

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CHRONIC DIARRHEA is a condition which, not infrequently, puzzles most of us in the search for the cause and ultimate effective treatment. The patient with chronic diarrhea may have a history of symptoms going back for months or years so that, at times, it is not only the primary cause of the diarrhea which has to be determined, but frequently, the secondary complications have to be evaluated as possible perpetuators of the diarrhea.

The patient who has a chronic diarrhea needs a complete checkup by history, physical examination, and laboratory tests and by the various auxiliary diagnostic methods.

In order to appreciate the magnitude of the chronic diarrhea problem and to apprehend the need and extent of a complete workup for such cases, a review of the various causes of diarrhea is herewith presented. As noted, chronic diarrhea may be due to one or a combination of the following factors, and can, accordingly, be classified into the various types:

1. *Gastrogenous type*—due to a primary achlorhydria or following gastric operations (gas troenterostomy, gastric resection).

2. *Pancreatic type*—due to deficiency of pancreatic enzymes.

3. *Chronic Gallbladder disease*—due to associated gastric (achlorhydria) and chronic pancreatic disease; rarely, it may be due to a fistula between the biliary and the gastro-intestinal tract.

4. *Constitutional disorders*—e.g., allergy, diabetes, hyperthyroidism (both due to achlorhydria and to neurogenic hypermotility of the gastro-intestinal tract), and chronic nephritis.

5. *Functional disorders*—e.g., chronic constipation with its associated prolonged use of purgatives; fecal impactions; mucous colic; and emotional diarrhea.

6. *Neurogenic disturbances*—reflex disturbances from extra gastrointestinal pathology—e.g., diarrhea secondary to 1) intraabdominal abscesses, 2) renal or biliary colic and central nervous system disease (tabes).

7. *Gynecological diseases*—endometriosis, post irradiation enteritis or colitis.

8. *Iatrogenic factors*—diarrhea following the ingestion of drugs—especially the newer antibiotics.

9. *Defects in absorption*—due to idiopathic steatorrhea, tuberculous mesenteric glands, deficiency states (pellagra, sprue), and intestinal carbohydrate dyspepsia.

10. *Diseases of the Intestine:*

A. *Infections*—due to shigella (bacillary dysentery group) or salmonella (typhoid and paratyphoid) organisms, fungi, and lymphopathia venereum.

B. *Parasites*

1. Protozoa—ameba histolytica, Giardia lamblia, trichomonas hominis, Balantidium coli, leishmaniasis, etc.

2. Helminthes—various types of worms.

C. *Toxic Drugs*—diarrhea following arsenic, mercury, and alcohol.

D. *Neoplastic Diseases*—polyposis, and carcinoma.

E. *Anamolous Conditions*—megacolon, diverticulosis.

F. *Inflammatory Conditions*—diverticulitis, factitious proctosigmoiditis.

G. *Ulcerative Diseases*—chronic non-specific enteritis and enterocolitis, tuberculosis of the intestine, and chronic non-specific ulcerative colitis.

* Read at a postgraduate meeting of the Indiana Academy of General Practice.

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From the above outline, it is evident that the workup of such a chronic diarrhea case requires a very exhaustive study to cover all the possible causes.

In the history of the patient, one has to look for changes in dietary habits; for exposure to toxic substances, e.g., by working in places where noxious materials may affect the patient; and for travel to areas in which various forms of diarrhea are endemic (service in the armed forces is frequently a predisposing factor). The hygienic circumstances of food and water supply, the patient's habits as to laxatives, bowel movements, and fluid intake; and his reactions to emotional stimuli must be carefully evaluated as possible factors in chronic diarrhea. The results of operations on the gastro-intestinal or biliary tract for any cause should be carefully considered as possible causes of diarrhea.

In the symptomatology one should elicit whether there is alternating constipation and diarrhea. Is abdominal discomfort associated? If yes, when—before, during, or after the bowel movement? Is there associated flatulence or tenesmus? Is mucus or blood or both seen on the stool or separately? Are the movements explosive with much gas? Are nausea and/or vomiting associated with the abdominal pain and discomfort? Is there a general feeling of weakness, sweating, fainting, preceding or following the bowel movement?

In the physical examination, one should look for the general appearance of the patient, i.e., is he obese, emaciated, or of normal weight. Any changes in the color of the skin (chronic jaundice, pigmentation, bronzing) and signs of dermatitis with or without hypersensitivity stigmata (urticaria) should be noted. The presence of enlarged lymph glands, edema, ascites, localized swellings, lack of hair, or excessive hair growth over the body should be looked for. The appearance of the tongue and any signs of vitamin deficiency around the angle of the mouth, corners of the nose and corners of the eyes are significant. The presence or absence of a lead line should be checked and also the hygienic status of the mouth relative to the teeth. The presence of an enlarged thyroid gland; of exophthalmos; of a fine tremor of the hands; and of pathology in the chest or heart should be noted. The size and consistency of the liver, size of spleen, and appearance of abdomen may

be of aid in determining the cause of chronic diarrhea. The presence of collateral veins, palpable loops of bowel or tumors in the abdomen should be noted. Any unusual ulcerations of the legs or on other parts of the body should be evaluated.

Rectal examination should be done carefully on all patients with chronic diarrhea. This examination should be done methodically, with the patients in squatting position and straining (rectal examination done only when the patient lies on his left side is not satisfactory). With the patient in squatting position and straining, a larger area of the rectal ampulla can be explored and sometimes a lesion that is out of finger reach in the left lateral position thus can be felt. The anal verge should also be carefully checked inasmuch as local peri-anal and sphincteric pathology may lead to reflex disturbances and frequent bowel movements. Furthermore, perianal fistula may suggest ulcerative, internal lesions; depigmentation and excoriations may suggest functional pruritus ani, but occasionally, helminthes or allergy may be the cause. During rectal examination, the possible presence of genito-urinary pathology as a reflex factor should be looked for.

In the female patient, pelvic examination may help in eliciting some primary gynecologic factor as the cause of diarrhea and should, therefore, be carefully done in all such cases.

Proctoscopic Examination—No patient with chronic diarrhea should leave the doctor's office (1st or 2nd visit) without a procto-sigmoidoscopic examination. If the diarrhea should be due to a malignant lesion, the sigmoidoscopic examination should result in finding the lesion in almost 75% of the cases. If it is due to an ulcerative condition, the appearance of the ulcerated mucosa usually helps in clarification of the underlying cause. During sigmoidoscopy, one may also obtain various specimens from the mucosa or ulcers for microscopic examination and biopsy can be taken for histologic examination of any neoplastic lesions. If no ulceration is found, the appearance of the mucosa (edema, bleeding, scarring, polypoid excrescences) may still be of diagnostic aid.

The stool examination is obviously very important in cases of chronic diarrhea. The ex-

amination should be done both for macroscopic appearance, microscopic findings and culture.

Macroscopically, one should look for amount, consistency, color, greasiness, food particles, mucus, blood, possible parasites and helminthes.

Microscopically, one should study the type of white cells (mono or multinuclear leucocytes, eosins) bacteria, parasites, and food rests—fat, cellulose, starch, and undigested meat fibres.

A word of warning concerning the microscopic examination for parasites is here in order. While every laboratory technician may be competent to examine stool for blood and fat, this does not hold true for examination for parasites. For the latter, one must have a technician trained particularly in parasitology. It is better to send a stool to a distant but reliable laboratory for "parasitic" examination, rather than to rely on an inexperienced "local" technician. Poor examinations of stool specimens account for many undiagnosed cases of amebiasis and other parasitic diseases in patients who continue with chronic diarrhea for months and years.

Stool cultures should be done for the various aerobic and anerobic pathogens that may cause diarrheal conditions. In some instances, cultures for yeasts and fungi are also indicated.

X-Ray Examination—A complete gastro-intestinal x-ray examination is imperative in every case with chronic diarrhea. This should include not only the customary "esophagus, stomach, duodenum, and colon" but also a careful study of the small bowel and biliary tract. The colon examination should be done with both barium and air.

Laboratory Workup

Gastric analysis preferably with the histamine test meal (0.1 mg. per 10 kg. of body weight) should be done in these patients to rule out an achlorhydria.

Urinalysis: Urine examination will show possible presence of glycosuria, albuminuria, bilirubinuria and presence or absence of urobilinogen.

Blood Count: Cytologic examination of the blood will show the presence and type of anemia, type of erythrocytes, leucocytosis or leucopenia, eosinophilia, lymphocytosis, etc.

Blood Agglutination Tests if positive, will show the presence of some types of Salmonella or Shigella infection.

Blood Chemistry: The levels of the blood glucose, blood urea, cholesterol, albumin globulin, calcium, phosphor, alkaline phosphatase are of importance in evaluating the given case of chronic diarrhea.

Serology should be checked. *Basal Metabolism Rate* should be done to elicit a possible hyperthyroidism.

While the above outlined workup is necessary in most of the cases with prolonged diarrhea, it may, nevertheless, be justifiable to briefly discuss some statistical figures as to incidence of the various types of diarrhea since this may help us, at times, in a complicated case. Thus, the causes of chronic diarrhea in the frequency of their incidence can be given as 1) emotional, nervous origin, 2) chronic ulcerative colitis, 3) carcinoma of colon, 4) gastrogenous origin, 5) amebic colitis, 6) constitutional disorders, 7) functional (chronic constipation), 8) defective intestinal absorption, 9) constitutional disorders, 10) disorders of gallbladder and pancreas, 11) nutritional deficiency states, 12) tuberculous enteritis and non-specific enteritis. It is thus apparent that if the first one-half dozen possibilities are quickly ruled out, the others will be less often bothersome.

Clinically Important Conditions

Ulcerative colitis (idiopathic) is one of the most common causes of chronic diarrhea. Its etiology is, at present, unsolved. It occurs most frequently in the rectum, sigmoid, and descending colon and spreads upwardly. It is more prevalent in the cooler climates, affects both sexes about equally, but is more prevalent in the young (80% below 40). Many patients give histories of previous gastro-intestinal disturbances, varying from food poisoning to dysentery. It may appear as a mild or severe form and go on to a chronic, relapsing form. Sepsis, loss of weight, and various endocrine and growth disturbances are associated with its severe form. In its chronic form, it may result in polyposis (Figure 1) (about 10% of the cases in the higher age group), in stricture (about 10%), perforation (rare), perirectal or pericolic abscesses with fistula formation into vagina,



FIGURE 1—Multiple radiolucent areas suggestive of polypoid changes in a young male with symptoms of ulcer. Colitis of four years duration.

bladder, perineum, or other areas and occasionally a carcinoma may develop from the polypoid growths. Nutritional deficiency syndromes, skin lesions, eye lesions, bone and joint and hepatic involvement may occur. Occasionally, massive hemorrhage is a very serious complication.

Carcinoma of the Colon is another common cause of chronic, bloody diarrhea and should be suspected in any patient over 35 years of age who develops suddenly, changes in bowel habits associated with abdominal discomfort, peristaltic unrest, increasing abdominal distension associated with loss of strength and unexplained anemia. Loss of weight is not a necessary sign of carcinoma of colon.

Polyps of the colon, because of their potential malignant character must be carefully ruled out as causes of chronic diarrhea. They are present in about 10 percent of examined patients and their malignant character varies from 17-51 percent according to various statistics. They occur more in the male and in white people and are usually diagnosed like the carcinoma by

x-ray and sigmoidoscopy. Only the histologist can differentiate between a benign and malignant polyp.

Amebic Colitis—In some areas, this is a very common cause of chronic diarrhea, since its incidence in the population varies from 10-40 percent. The accurate diagnosis of this condition is very important, not only for the patient, but for others as well, since it is carried by contaminated food or drink and food handlers are, therefore, very dangerous. This condition may occur in children, too. Usually, it is seen mostly in men because of greater likelihood for exposure. While commonly not serious, it may occasionally develop serious complications, such as amebic hepatitis, amebic abscess of liver, perforation and intestinal hemorrhage, pulmonary lesions, brain abscess and intestinal granulomas that simulate carcinoma.

Diverticulitis—While not very common, it is often a difficult diagnostic problem in chronic diarrhea. Diverticulosis (Figure 2), which occurs in about 5 percent of the adult population is, as a rule, not serious. However, if an inflammatory process occurs in one or more diverticuli, various symptoms and signs of a constricting neoplastic lesion may arise (Figure



FIGURE 2—Numerous diverticuli in the sigmoid and descending colon in an elderly male complaining of intermittent diarrhea and constipation associated with pain in the left side of his abdomen.

3). Actual perforation of infected diverticuli has been reported.

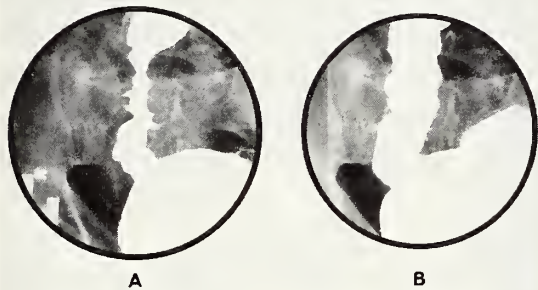


FIGURE 3

A) Long, irregular, constricting defect in the sigmoid portion of a 56-year-old male with obstipation, tentatively diagnosed as carcinoma.

B) The same segment as in A, six weeks later, after treatment with antibiotics, soft diet and anti-spasmodics.

Treatment

The treatment of chronic diarrhea cases obviously depends on the underlying cause. In many of the patients in whom the diarrhea is due to lack of some substance as acid or pancreatin, the administration of such substances will relieve the symptoms. In others, additional dietary and medicinal therapy will be necessary. The diet in most of these cases should be high in calories and protein, moderate in carbohydrates and fats and divided into several small meals daily. The carbohydrate and fat content of the diet may have to be modified as improvement in the condition occurs. All vitamins should be given liberally. Supportive treatment in the form of blood transfusion and other intravenous solutions for maintaining the electrolytic balance may be necessary. Iron, antibiotics, sulfonamides, parenteral liver and vitamins may be indicated as supportive and, at times, as specific treatment. Thus, for the *Salmonella* and *Shigella* infections, one of the antibiotics is helpful. For the amebic infection one of the newer antibiotics or the older iodine or arsenical preparations with or without emetine should be used. For the helminthic infections, one of the numerous vermifuges has to be used.

In cases where the basis for the diarrhea is surgical, operative interference is an immediate must. Carcinoma of the colon has to be re-

sected as soon as the patient can be prepared. Other causative lesions,—like polyposis and diverticulitis—are controversial factors. In general, it may be said that if one or more polyps are within the reach of the snare and fulgeration apparatus through the sigmoidoscope, they should be removed and the base fulgerated. The patient should be reprocotoscoped at frequent intervals for possible recurrence of the lesion.

The finding of short or long constrictions in a patient with diverticulosis may mean that the patient has 1) diverticulitis, 2) carcinoma, or 3) both conditions. If the patient has few symptoms and the lesion is very questionably malignant, intensive medical treatment with liquid diet, sulfasuxidine and antibiotics can be given for 2-3 weeks and then the lesion checked by x-ray. If no change, immediate surgery is indicated. During the operation for such a lesion, the surgeon has to resect similarly as if it were a proven malignancy. Biopsy of the mass is not advisable inasmuch as the frozen section taken from a superficial portion may be benign—the malignancy lying deeper—and the surgeon may thus, do only a colostomy, for the temporary relief of the “inflammatory” obstruction.

The most difficult therapeutic problem is encountered in ulcerative colitis. During the acute stages, the patients should be in bed on a high protein, high caloric diet, on multiple small feedings; they should receive all vitamins orally or parenterally; blood transfusions when necessary; and antibiotics and/or sulfonamides (*Azopyrine* has recently proven itself quite useful in this condition). In the acute fulminating cases, ACTH has proven itself of some benefit.

In some cases of ulcerative colitis, the question of surgery arises. Usually, it is believed that surgery is only indicated when there is persistent massive hemorrhage, distension of colon with imminent perforation, perforation, stricture, perineal or perirectal fistula, and carcinoma. Some believe that polypoid changes and severe arthritis are also indications for surgery.

The patient who is operated on should be made to understand that he will have a permanent ileostomy. Some believe that ileostomy and partial colectomy should be done immediately. Others, that ileostomy should be done at

first and that colectomy should be reserved for a later date when the patient has fully recovered from the condition requiring ileostomy. I have known of some cases who, after 20 years of ileostomy have had no need for colectomy. Nevertheless, one must keep in mind that the pathologic colon, while inside the body may cause, at some future date, trouble unless nature causes it to "involute" (Figure 4).

Patients who have a permanent ileostomy, can now carry on a fairly normal life with a little adjustment and will power. The development of the newer ileostomy bags, dietary and medicinal progress have made the life of patients with ileostomy much more tolerable. Cases are on record of girls with ileostomy bags getting married and having children.

Patients who have chronic diarrheal conditions may develop secondary disturbances in other organs too. Fistulae—intra and extra abdominal—have already been referred to and these may mask and obscure symptoms. Nutritional disturbances with their sequelae may be secondary to chronic diarrhea. Hepatic involvement specific (as amebiasis) or toxic or metastatic is not uncommon. Involvement of the urinary bladder, ureters, and kidneys is occasionally a complicating factor of chronic diarrhea.

Summary

A discussion of the various causes of chronic diarrhea has been presented, with stress on the manifold causes for it.



FIGURE 4—Narrowing and shortening ("involution") of the distal segments of the colon six years after ileostomy (the ring in the left-hand side is part of the ileostomy bag) in a 45-year-old female, completely symptom-free at present.

Some of the most common causes have been enumerated and the procedures for workup of cases of chronic diarrhea have been outlined.

The most common clinical conditions associated with chronic diarrhea, their incidence, diagnosis and treatment were presented.



Announce New Journal

The new publication of the American Geriatrics Society which will appear shortly is to be known as the Journal of the American Geriatrics Society. Additional information concerning both the Society and the Journal may be obtained from the permanent secretary, Dr. Malford W. Thewlis, Wakefield, R. I.

THE JOURNAL

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CYRUS J. CLARK

CY CLARK died on January 22 as a result of injuries which he sustained in an automobile accident two days previously. When he was hurt he had been calling on patients and was returning home after his last house call. His car was thrown against a bridge when one of the tires blew out.

Although he passed away while still a young man, Cy had lived an extremely full and busy life. He was active in each of the many organizations to which he belonged. His practice itself was his basic interest, and to this he added an almost overwhelming number of associated ac-

tivities to which he gave of his time and energy without limit.

Cy never met a stranger. He was a friend of all his patients and of everyone else he met. His was a dynamic life, lived to the fullest.

To quote editorial comment: "Perhaps he never thought of himself as a great public relations man for the medical profession, but few of its members did more in its interests than he. Not only his profession, but all of Indianapolis, will miss the busy and useful life that yesterday was cut so tragically short."

TRUMAN COMMISSION ON HEALTH NEEDS

EVERYONE should read the "Statement on Report of the Truman Commission on the Health Needs of the Nation." It is a statement by the Board of Trustees of the A.M.A. It appeared in the *Journal of the A.M.A.* in the issue of January 24, 1953.

The Trustees' general appraisal of the Commission's report emphasizes a fault of the project which was apparent from the start and is even more obvious now, i.e., too short a time was allotted for such an enormous task.

The Commission was directed to study health expenditures at Federal, State and local level and to recommend the desirable expenditures at these levels in relation to other government obligations and with consideration of expenditures from private sources. The A.M.A. Trustees feel that the issues involved in this part of the directive are of paramount importance to the nation as a whole. They fail to find, however, that the Commission has made any findings or recommendations in this regard.

In fact the Commission has recommended increased Federal spending as the answer to almost every problem. A total of 33 federal appropriations, amounting to an increase of over two billion dollars is involved. No evidence is presented to indicate that the nation would be able to assume this additional tax burden.

The basic philosophy of the report is evidently that of the welfare or socialistic state. Health is recognized as being partially dependent on food, housing and education; with the implication that Federal control of all these factors is desirable. As a part of this philosophy the Commission recommends federal subsidy for medical education.

Another important question—that of failure of the federal government to coordinate its own activities in the field of health and medical care—is left unanswered. The A.M.A. points out that this is a field in which information is readily available and in which remedial measures could be most quickly effected.

Compulsory health insurance is advocated for the beneficiaries of the Social Security System. This recommendation, which has been rejected by an overwhelming majority of the citizens, casts an element of doubt on the entire report and upon all other of its recommendations.

Complete analysis of the Commission's work must await publication of the entire report, which is being published in reverse order. Volume 1* contains all the conclusions and recommendations; subsequent volumes will present the supporting data.

* Volume 1 may be purchased from the Government Printing Office at 50 cents per copy.

GAMMA GLOBULIN AND POLIOMYELITIS

RECENT experiments have demonstrated that gamma globulin, produced from the pooled blood of many persons, contains antibodies which attack one or more of the three strains of polio virus. A dose of the serum, which requires approximately one pint of blood to produce, protects against the paralyzing effect of polio for about a month if injected after exposure to the disease, but before the virus reaches the nervous system.

Gamma globulin has been used in the past in the treatment of measles and infectious hepatitis. Its proposed use in poliomyelitis will greatly increase the demand. It is probable that the available supplies will be controlled and allocated during the next year's expected polio epidemic. The demand almost certainly will exceed the supply.

A special panel of seven physicians has been formed by the National Research Council to

allocate the limited supply in the most equitable and useful manner. The American Red Cross is assuming responsibility for procurement and production cost of gamma globulin. The cost of processing serum albumin—another fraction which is obtained from the same blood—is being assumed by the Department of Defense. The Office of Defense Mobilization has taken over responsibility for distribution.

The supply of gamma globulin which is available for civilian use has recently been increased by two million cubic centimeters. This amount was released by the armed services. The total amount now available to civilian use approximates one million average doses. (An additional two million cubic centimeters are earmarked for measles and infectious hepatitis).

In spite of recent increases, the use of gamma globulin for polio will be limited strictly to epidemic areas. The general public must realize that sub-epidemic areas during the next polio

season, which have contributed to the globulin supply this winter, probably will not be allocated the drug so long as the area remains at less than epidemic levels.

The Red Cross is expanding its blood collection program in order to increase the supply of globulin. It will continue to collect blood, as in the past, to meet the needs of civilian hospitals and the military services for whole blood, and to add to the nation's reserve of plasma for military and civil defense purposes.

Gamma globulin as an agent against poliomyelitis will exert a tremendously popular appeal. Blood collection centers may experience a marked increase in the number of volunteer donors. In order to conduct blood collection so as not to interfere with the supply of blood for other purposes, and in order not to interfere with non-Red Cross blood banks, the Red Cross is seeking advice and counsel from medical societies and blood bank committees.

Letter to the Editor

Executive Office of the President
Office of Defense Mobilization
Washington, D. C.
National Blood Program

Dear Sir:

Confronted with the growing blood needs of the country, the President recently recognized blood as a national resource by placing responsibility for the coordination of all blood activities in the Office of Defense Mobilization.

The total blood needs of the nation are great: blood is needed for current use by the Armed Forces; it is needed to fill the immediate requirements of civilians; and above and beyond these daily needs, there must be blood for a national plasma reserve ready for use in any emergency, civilian or military, which might arise. To fill all of these important and continuing needs, the National Blood Program needs your support in persuading the American people to become regular blood donors.

Sincerely,

PAUL GAYNOR
Coordinator
National Blood Program

Université de Montréal.

Re: *Request for reprints concerning stress and the adaptive hormones.*

Case Postale 6128, Montréal.

Dear Sir:

In perusing the current literature with which this journal is concerned, we note that an ever increasing number of its articles deals with problems pertaining to research on "stress" and the so-called "adaptive hormones" (ACTH, STH, corticoids, adrenergic substances, etc.).

We are writing you because, in our opinion, the success of research in this complex and rapidly developing field largely depends upon the prompt availability and evaluation of relevant publications, a task for which we should like to solicit the assistance of your readers.

In 1950, our Institute has initiated the publication of a series of reference volumes entitled "Annual Reports on Stress" (Acta Medical Publishers, Montreal) in which the entire current world literature is surveyed every year (usually between 2,000 and 4,000 publications). Up to now, we had to compile the pertinent lit-

erature partly from medical periodicals, monographs, abstract journals and partly from reprints sent to us by the authors themselves. Of all these, reprints proved to be the best source of data which we felt deserved prompt attention in our annual reports. Hence, in the past, we have sent out several thousand individual reprint requests to authors of whom we knew that they are currently engaged in research on stress and allied topics. Even this procedure did not give us the wide coverage which would be desirable, because it is materially impossible to contact all these authors individually and it often takes too much time to get the requested reprints.

It is evident that in order to insure prompt inclusion of publications in the annual reports, these surveys must develop into a cooperative

effort between the authors of original papers and the reviewers. This cooperation was greatly enhanced of late by the publication of announcements, in several medical journals, encouraging investigators interested in stress research to send us their reprints for this purpose as soon as they become available.

We should be grateful if by the publication of this note, you would also bring this problem to the attention of your readers.

We are Sir,

Very sincerely yours,

Alexander Horava, M.D., Co-author of the "Annual Reports on Stress."

Hans Selye, M.D., Ph.D., D.Sc., F.R.S.(C), Professor and Director of the Institute of Experimental Medicine and Surgery

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

CAR DESIGN AND ROAD ACCIDENTS

You have a better chance of escaping serious injury in an automobile crash if you remain inside the vehicle. Exceptions, of course, would be in cases of fire or submerging of automobiles in water.

Sgt. Elmer C. Paul of the Indiana State Police brought out this fact in a talk before the Howard County Medical Society Tuesday night. Sgt. Paul began making investigations in 1949 to make traffic safer, and his efforts are given credit in an article by Herbert Yahraes which appears in the current issue of Collier's.

The sergeant analyzed fatal accidents to learn where modern car design may be held responsible. He found during the past year and the year before that an average of 66 per cent of fatalities could have been avoided by changes in car design. His statistics show that the most dangerous place in an automobile is the right front seat. Occupants of that spot are tossed against objects in the front of the car, or doors burst open and the passengers are thrown out and fatally hurt in the fall.

It is to the credit of the automobile industry that it is working to overcome these hazards. One thing the industry is trying to do, Sgt. Paul told the local

doctors, is to design an automobile door that will remain closed after an impact. Sgt. Paul may turn out to be a man whose efforts went far to make motoring much safer in the United States, and that would be a recognition of which anyone could be proud.

The medical society here also heard some interesting facts about persons who drive cars while under the influence of intoxicants. Lt. R. F. Borckenstein, also of the state police, pointed out the distinction between the drinking driver and the drunken driver.

The drinking motorist is the more dangerous, he said, because the driver who has reached a stage of drunkenness either is completely incapable of driving or his friends will prevent him from getting behind the wheel. Compared to a non-drinking driver, the person who is partially intoxicated has 55 per cent more likelihood to have an accident. Alcohol impairs his judgment and leads him to take foolish chances, causing injury or death of others.

Those who drink and then drive are taking enormous risks. It is difficult to see how they can expect to be excused or acquitted of guilt when they cause an accident.—*Kokomo Tribune.*



President's Page



FELLOW MEMBERS OF THE I.S.M.A.:

"**M**EDDLING with another man's folly is always thankless work" but since the folly which is to be discussed concerns the desultory efforts of health minded socialists, the melody may not vibrate on unresponsive ears. Volume One of the **exhausting** five volume report of the Nation's Health Commission desires to reduce the taxpayer to a state of mendicacy. Limited space permits the mention of a few obvious reasons.

Most of the report was common knowledge prior to publication because we have been reading for several years the socialistic theories of Falk, Perrott, Davis, Cohen, Kingley, Altermeyer, Ewing, and other students of health without M.D. degrees. A majority of the Health Commission changed the idea of Federal Control to optional State Control (another wolf in sheep's clothing) which was objected to by Hayes, Magee, and Reuther in a minority report. Like these dissenters the Commission had in mind ultimate compulsory sickness insurance, but by-passed it for the record with some sugar-coated recommendations which are to be implemented by their usual method, viz: another chunk out of your income to the tune of \$1,018,000,000. Mind you, this would be in addition to the \$2,209,341,210 which the F.S.A. expects to spend in 1953. This extra billion is designed to act as a stimulus to county and state spending; of course, subject to Federal approval. Of this billion, they suggest a mere \$100,000,000 to train health personnel and a mere \$750,000,000 for grants-in-aid to states to assist in the provision of health services. Thus, \$3,227,341,210, plus compulsory matching millions of 48 states and territories, indicates further mismanaged and wasteful spending of public monies as a solution of unmet medical needs.

The Health Commission outlining this chimeric health plan laments the fact that the nation spends only \$6,000,000 a year for research in the neglected field of mental health. This may be included in the budget of the Mental Health Institute which spent \$10,895,000 in 1952-53 and proposes to spend \$15,500,000 in 1953-54. It would appear that if all health agencies, voluntary and governmental, could spend a total of \$6,000,000 for research on any one disease, in any one year, no disease would be neglected. Why? In doing research on any disease in any one year there are only so many practical problems to research. Future research is always based on previous investigation and extra appropriations and contributions for research too often throw the taxpayer's inflationary dollar down a rathole. Extra monies, then, are used for salaries and additional personnel, and the ballyhoo of monies for research and the patient's welfare is just so much whistle bait. Sympathy and ambition to wipe out "disease killers of mankind" should not overshadow wise investigation and practical spending.

Volume One's combination of many health suggestions presents no master plan of reorganization and decentralization. Money is their only remedy. By the time the taxpayer pays the Commission's contemplated budgets he will

have additional unmet clothing and caloric needs besides unmet medical needs. These unmet medical needs are exaggerated by the Commission itself, even though now they are aggravated by the drain of medical personnel in the armed forces and the competition for nurses and physicians from unnecessary government hospitals with civilian hospitals. The Commission desires to have medical care purchased by Social Security funds through payroll deductions which means less take-home pay and unprecedented government control. A measure which might initiate a solution of their inscrutable recommendations would be to take all the money which F.S.A., voluntary health agencies, and state and local governments spend on health and welfare, reallocate it, release a host of employees, and then disburse it economically. If you were given a free hand, how would you spend the 1953-54 colossal requests of the following Institutes—Cancer, \$22,000,000; Heart, \$15,500,000; Arthritis and Metabolic, \$8,450,000; Neurology and Blindness, \$7,670,000; Microbiology, \$7,000,000? And it takes more money to operate an Institute than it does for F.S.A. to control venereal disease at \$8,325,000, tuberculosis at \$7,645,000, communicable disease at \$5,735,000. Add to these figures the contributions to voluntary agencies. For example, the National Tuberculosis Association raised \$21,717,953 in the fiscal year 1951-52, and in 1952, our citizens subscribed to the March of Dimes (Infantile Paralysis) \$41,432,605, Cancer \$16,400,000, and Heart \$7,000,000. The National Heart Association desires \$10,000,000 in 1953.

Unfortunately, most of the money raised voluntarily in any civic health campaign or allotted to any governmental health budget, through taxation, is delegated to administrative expense. Volume One does not mention the duplication of health work, health workers, swivel chair executives, and statisticians. What we need is a Study Commission made up of members who have never been employed by F.S.A. to correlate, streamline, and economize voluntary and governmental health budgets and objectives, or better yet a Federal Security Administration which realizes the difference between sentimental folly and medical wisdom. Their recommendation that "administrative research should receive a higher priority in our scale of values" should be relegated into the cloaca of political medicine. The Commission urges us insouciantly to portentous extravagance which is bound to yield more, instead of less, inadequate medical care.

Paul D. Crimm M.D.

P. S. Well—Henry Watterson was rebuked at one time for criticising the Governor of Kentucky. Mr. Watterson replied as follows, "Things have come to a pretty pass when a man can't cudgel his own jackass."

P.D.C.

CONSIDERATIONS ON MEDICAL ETHICS

DR. K. L. KAUFMAN*

Indianapolis

GENTLEMEN, this paper is intended to serve as a basis for a discussion, and not just as an historical review of the subject. For that reason, my references to many writings will be somewhat more brief than you may have anticipated. It also should be made clear that this paper is intended to be neither a "whitewash" nor a "witch-hunt".

There is real value in open-minded consideration of problems of professional ethics. I know this because I have seen the good of such discussions demonstrated, both as participant and auditor. We all need to be reminded occasionally, as Eby put it in her "Quest for Moral Law", that the "term 'moral law' has lost all precision of meaning for the mind of the twentieth century".

"Ethics" is a word often used loosely. Let us begin by defining our term. First of all "professional ethics", we must understand, cannot be divorced from the more broadly inclusive term "ethics". You may recall that this latter word comes from the Greek "Ethos", meaning character or habit. What is character? For the present purpose, let us say it is the sum of our habits and customs. But habits and customs are *matters of choice*—they may be good or bad. Thus, the phrase "moral law" is often applied to ethics, because the word means the *right* conduct; the power of a *largely unwritten law* is implied. The terms value (or good), and obligation (or duty) are other basic concepts implied in the term "ethics".

The term "professional ethics" simply differs from general ethics, then, in that it applies to a limited group, and is intended to guide the personal actions of the members thereof. Most written codes of ethics list in a more or less

general way the proper actions and attitudes to exhibit toward one's fellow professionals, toward his patrons, and the public generally. This is true whether we are referring to physicians, or accountants or warehousemen. In fact, many sections of your code, could be amended only slightly, and substitute nicely for a comparable section in another code.

It is probable that some men were seeking light on ethical questions before the dawn of written history. Of course, we cannot be certain of this, but we do find evidence that man had reached this stage of development long ago. If we look to the earliest known laws and writings now extant, we will note certain reflections of the ethical spirit.

Early Writing on Ethics

The Egyptians planted the first seeds of thought which were to lead to a monotheism. Also, they had some concepts of justice and decency. This was the extent of their contributions to ethics.

The ancient laws of King Hammurabi (*ca.* 2200 B.C.) were devoted in part to the regulation of the practice of medicine. Since these sections dealt with charges to be rendered for certain services, they have been called "Fee Codes". However, these same parts also delineated punishments for failures in treatment, and gave certain directions to be followed in some cases, e.g., laying the sick in the street, where all could see and offer advice. The "Ass Doctors" were under somewhat similar restrictions.

The Mosaic law is derived largely from these early Egyptian and Babylonian-Sumerian writings. Regardless of their ethical shortcomings, these early manuscripts show that a conscience and an interest in their fellow man existed among some, at least, of the early peoples.

Ex Oriente Lux, ex occidente lex. This old Latin Proverb can well apply to the change in professional ethical concepts which occurred in

* Dean Kaufman, Dean of Butler University's College of Pharmacy, presented this paper before the Fayette-Franklin County Medical Society on January 13. Dean Kaufman, who was a member of the faculty of the Medical College of Virginia before coming to Butler, has published several articles on this general subject.

the fifth and fourth centuries before Christ. The gropings of man through many millenia prepared the way for the Greek philosophers—who spread the light, so to speak, and wrote the laws of ethics. Not until this period had it been possible for individual man to develop his thoughts and to speak and to write them freely. So the history of this ancient people abounds with such great names as Socrates, its man of action; Plato, its man of literature, and Aristotle, its man of sciences. As all of you are aware, the world owes much to these and other men of this age, owes much to these and other men of this age, than the professional men and women today. I say this because professional people must be characterized by a conscience and a desire to serve their fellow-men, which are not anticipated in, nor expected from their compatriots in the trades. Part, at least, of the inspiration for the first great ethical statements on the practice of medicine came from these great writers.

The Hippocratic Oath gave to medicine its highest moral inspiration, perhaps of all time. Greece, as a country was succumbing to a life of pleasure and selfishness. The more philosophical could discern the trend. The effects were noted in the practice of medicine, and some individuals wanted to do something to curb the tendency. So, the Oath was written. It is the first document which bears resemblance to modern professional codes.

In the second paragraph the neophyte expresses his complete allegiance to his professors and their children, to his own sons, and to those who abide by the Code. This portion is notable for the implication that the art of medicine was to be kept in the proper families. History tells us that the Asclepiades were largely composed of family dynasties.

The next two paragraphs state the principle and give certain examples of the necessity of using one's technical knowledge for the good. Thus, they recognize one of the great ideals of medical practice. I believe that this represents the first time in history that such a statement appears with respect to any profession. Hippocrates has come a long way from the code of Hammurabi.

Another two paragraphs are similar in principle—they reaffirm the ideal of service, and add

injunctions of purity, especially against wrong actions, and of the privacy of the patients' lives.

Few Injunctions Voiced

The Oath concludes with a final promise of diligent observation on pain of losing honor, both in his life and in his profession.

For the most part, this oldest of the Codes is generalization. There are only five specified prohibitions with respect to practice. This factor is unusual, too, because as we have seen, the principle ethical references in earlier laws are specific injunctions as to the size of fees, punishments, etc. It would appear that the code's unknown authors had considerable confidence in the ability and especially in the judgment of their professional colleagues. Of course, the injunctions against certain acts probably are reflections of the most common forms of malpractice at the time the Oath was written.

Attention should be drawn to the fact that there is nothing in the Hippocratic Oath compelling the physician to disclose any new discoveries. Such were usually kept secret.

Hippocrates also has been credited with other writings which are of an ethical nature. Chief of these is the "Law" or "Standard". This document is a series of five statements designed to distinguish qualified physicians from quacks, and to set some standards for teaching and practice. It is highly ethical in its character.

Both the Oath and the Law have undergone numerous revisions in many lands. Their ethical values have given them a universal vitality and carried them down through the ages.

The Christianized form probably dates from the tenth or eleventh century. In 1269, an Arabic version of the Oath was published. An Indian form of the Oath appeared in their literature at an early date. This variation is interesting in that it indicates their religious restrictions, and refers to the gift of medical services without charging fees.

The other most influential man of science during the Graco-Roman period was Claudius Galen, who lived from 131-201 A.D. His writings have earned him the title of "Father of Pharmacy," and "Founder of Experimental Physiology." Brock has devoted a section of his book to Galen's ethics. Galen never prepared an Oath or Law, but wrote frequently on subjects of an ethical nature.

Roman medicine was in a low state of development both ethically and professionally, long before the fall of the old empire. When the capital was moved to Constantinople, in 330 A.D., the leading professional men went along. Most of the great medical works were lost, and there were few available to replace them.

Nevertheless, the Byzantines did much to preserve the old knowledge. Some of this was done by Christians in exile and some by Jews and Mohammedans. Ethically and scientifically, the contributions were slight throughout the Middle Ages.

One of the few additions to the literature of professional ethics which came from the Christian world during the Dark Ages was the "Oath of the Faculty of Medicine," at the University of Montpellier in France. Founded in 1141, it soon became a notable institution. Colleges of medicine, law, and a course in pharmacy were established with the passing of time.

Statement Ignores Surgery

Three changes stand out when the Montpellier statement is compared with the various forms of the Hippocratic Oath. They are:

1. No reference to Christ, or to the pagan deities. It is suggested that this may have been due to the presence of many Jews on this faculty.
2. Absence of reference to the use of the knife. Although surgery was not yet considered to be on the same high plane as medicine, more physicians were using it than in the days of the old Greeks, and others were completely ignoring the scalpel. Hence, the reference was unnecessary.
3. The neophyte promises to give service without fee to the needy, and never to charge anyone an unreasonable fee. This reflected a criticism which was common in those days, as it is now.

The rest of the Oath could almost be considered a re-phrasing of Hippocrates. The same ideals and injunctions are there, although we do find them still more generalized in content. You will note quite a change in this matter of specificity when we come to the 19th century.

One notable Oath or Prayer was attributed for many years to the Spanish-Jew physician whom we generally know as Maimonides. This

prayer has received much attention among students of professional ethics because it was believed that Maimonides wrote it especially for the members of his own faith.

Aside from the items mentioned, the production of writings on professional ethics was relatively scanty until the beginnings of the nineteenth century. Most of the leaders in medicine, when they paid any attention whatsoever to the subject, echoed the admirable ethical principles of Hippocratic writings. Isaac Judaeus in the tenth century, and Henri de Mondeville in the fourteenth, probably reflected the attitudes of the majority of the physicians of the Middle Ages. They wrote sometimes on medical ethics, but their views were distinctly hedonistic. The idealism of the Greeks was nearly swallowed up by the meticulous details of the prescribed deportment. Pertinent to the material in question tonight was the emphasis on the ancient nobility of the profession shown in the writings of Guy de Chauliac, Paracelsus, Ambrose Paré, and Sydenham, "The English Hippocrates." All these men attempted to establish an *esprit de corps*, noble bearing, and personal honor in medical practice. The Royal College of Physicians adopted a *Statute Moralis* as early as the sixteenth century, which was designed to penalize physicians who violated the good traditions. Its effects were slight.

All the authors mentioned failed to leave us any new codes or oaths. They attempted to teach by precept and writing.

The real beginning of the modern professional codes stems from a publication of Sir Thomas Percival (1740-1804). He was a distinguished practitioner of Manchester, and one well ahead of most of his colleagues so far as his interest in matters of public welfare and protection were concerned. His famous work was published in 1803 under the title *Medical Ethics*.

The original edition consisted of 246 octavo pages, plus 16 introductory pages. It is divided into four chapters, a dedication, preface, and notes. The chapter titles and summaries of their contents follow:

I. "Of Professional Conduct Relative to Hospital or Other Medical Charities."

This chapter consists of 31 sections. It begins with admonitions to minister to the sick, and pro-

ceeds through such matters as choice of physicians, promotion of moral and religious influences for the sick, and many other subjects relating to practice in general and special hospitals.

II. "Of Professional Conduct in Private or General Practice."

This chapter contains 32 sections. It begins with a reminder that the moral rules of conduct applied to hospital patients should be observed in private practice. Detailed rules then follow on such matters as temperance, gloomy prognostications, interference with another's case, consultations, distinction between the provinces of physic and surgery, and seniority rules. The value of a regular academic education is stressed though it is not considered indispensable. The patient is told to respect the aid of the intelligent practitioner. Punctuality in keeping appointments is demanded of the physician, but unnecessarily frequent visits are proscribed.

One of the larger and most interesting sections deals with what Percival calls "pecuniary acknowledgments" of the patients. In these paragraphs, he points out the desirability of having some general rule in each town, and adhering to it, except for the poor or rich. On the other hand, he lectures the physician against "avaricious rapacity," and reminds him that knowledge, benevolence and active virtue are of highest estimation.

Three sections deal with those who should receive gratuitous service. These are primarily other physicians, surgeons, apothecaries including their wives and children, the clergy, and military or naval subalterns.

Percival Advances New Ideas

The physician is asked to discourage the use of "quack medicines" as disgraceful to the professions, injurious to health, and often destructive. He is told that he should not dispense a "secret nostrum", for if it is of value, "concealment of it, is inconsistent with beneficence and professional liberality." (This last reflects an important change from the Hippocratic or Montpellier forms).

Two sections deal with *esprit de corps* and controversies between physicians. In the first of these, it is pointed out that anyone entering a profession tacitly agrees to submit to the laws and to promote the honor and interest of the

group. If controversies cannot be settled immediately, they should be arbitrated by their fellow practitioners, but neither the subject matter nor the adjudication should be made public.

Another interesting section in this chapter calls attention to the importance of tracing back the steps taken in treatment of each and every case with fatal termination. While this will be valuable in future cases, Percival explains that he recommends the practice for moral reasons.

The last parts of the chapter take up the necessity for counselling patients who are "suffering under the consequences of vicious conduct". Also, the duty of observance of the Sabbath, and the problems of senescence and retirement from practice.

III. "On the Conduct of Physicians towards Apothecaries."

This is the shortest chapter of the Code. It has only nine sections. To understand its significance one must know that, in Percival's time, the apothecary in England, was a medical practitioner. He routinely took care of most of the medical cases in the rural areas, and frequently did the same in the larger towns. He also was responsible for the preparation of most of the medicines. The apothecary of that day was better educated than the chemist or druggist, and enjoyed more privileges than the latter.

For these and other reasons, the first section of this chapter points out the dependence of the physician on the knowledge, skill and fidelity of the apothecary. The next two sections suggest the desirability of conferring with him before a decisive plan of treatment is adopted, and of working cooperatively with him throughout the duration of the case. Still another section refers specifically to cooperation with the apothecaries of the small towns. The physician is told to help the apothecary to increase his knowledge in any way he can, and to learn too, of any practical improvements which may have originated in these areas.

In spite of these five tributes to the apothecary, the physician is then reminded to make an occasional inspection of his drugs. This was a law in London at the time, and Percival thought it a good idea. In 1804, the physician

was usually a fair practical botanist, so the inspections could be meaningful.

One section discusses the matter of the extravagant profits attributed to the apothecary. Percival feels that this charge is generally unwarranted and unfair.

The next to last section is curious because it is an injunction directed to the apothecary and not the physician. This practice was to become a habit with the medical code makers, as indicated later. It may mean that the authors of these were not fully cognizant of the true and full meaning of a professional Code of Ethics. The section deals with cases in which the apothecary and not the physician, is requested to recommend a physician, and attempts to tell him how to make a choice.

Finally, Percival tells his colleagues that they should support benevolent institutions for the widows and orphans of apothecaries.

IV. "Of Professional Duties, in Certain Cases which Require a Knowledge of Law."

This chapter consists of 20 sections. It deals briefly with some of the situations in which the physician may be asked advice by the sick or members of their families. He feels that they should be able to give counsel on will-making and other matters. He pays considerable attention in this chapter to laws regarding lunatics, coroners, homicides, malpractice, abortion, bastardy, poisoning, rape, and expert testimony. All of these are discussed largely from the moral point of view. Many are illustrated by actual case summaries.

The final part of the Code was titled "Notes and Illustrations." Many subjects are covered therein, some for the first time, some for the second. A part of them are directed to the moral side of the physician's life and actions. Most are quite long and not easily condensed for review. As they are not strictly a part of the Code, we shall omit discussion of them.

No man in modern times has written a document destined to have so profound an effect on the lives and behavior of most professional men. The American Medical Association, and similar organizations of medicine throughout the world were to acknowledge publicly their great debt

to Percival. Other professions imitated the Code, with changes appropriate to their callings.

It may be instructive to consider some of the reasons for the very great influence of this work of Percival. Prior to its publication in 1804, the medical profession had tried to handle its ethical problems on the basis of the Greek tradition of good taste and personal honor. The emphasis, when any attention was given to such matters, was on the spirit and not the letter. Of course, many failed to observe the spirit, either through ignorance or lack of professional conscience. Now, the physician had a set of rules, which directed his thoughts to the letter. Of course, this was inevitable, even though not one of the intentions of Sir Percival.

The Code was written on the basis of intuition and experience, and not on some one ethical principle. This was to lead to serious difficulty, because there were conflicts, real or suspected, in the rules.

Code Proves Controversial

It might be assumed that such a fine document as "Medical Ethics" would have received prompt and full praise from the practitioners. This was not the case. It did arouse physicians all over the world to a new appreciation of their moral obligations. Even the opposition to it was, in a way, helpful. In bringing matters out into the open and discussing them, thinking was crystallized and concepts clarified. The better physicians who accepted the Code sometimes helped to cause those who acted contrary to its principles to feel outlawed. As various medical societies adopted the Code or some modification of it, it had much greater force, for these small groups usually held the power of expulsion over any offenders.

The development to date can be traced as interestingly in the history of our own country as anywhere in the world. When Percival published his manual, American medicine was largely of the colonial style.

Religious leaders, governors and educators had been prominent as physicians in early American history, as they are in all colonial lands. Some practitioners combined pharmacy and medicine to make ends meet. Still others eked out a living with different combinations of vocations. As the colonies grew older, a few men began to go

abroad to study, and these usually confined themselves to medical practice upon their return.

Several colonial acts testify to the generally low state of medicine in these early days, e.g., the Fee Codes of Massachusetts (1649) and Virginia (1736). New York passed a law requiring an examination and a license to practice medicine in 1760. Shortly thereafter, the first medical college in the Colonies was founded at Philadelphia in 1765.

Medical Societies began to be organized shortly before the Revolution. Sometimes these groups included statements of general ethical principles in their by-laws. After the appearance of Percival's work, many societies began to claim acceptance of the Code or of its principles.

The rapid post-Revolutionary expansion of America and the paucity of laws, attracted many unscrupulous men to the practice of medicine. Educational facilities developed slowly, and morals dropped in the profession.

One of the most interesting attempts to develop higher standards of professional ethics occurred here in the Midwest at Transylvania College. Dr. Samuel Brown organized a secret fraternity of the better physicians which was called the "Kappa Lambda Society of Aesculapius." The intent was to promote high moral ideals within the group. They prepared an abridged edition of Percival's Code. It went through two printings and seems to have been widely circulated in the profession.

AMA Organizes

At the first regular meeting of the American Medical Association in 1847, requirements for minimal training and the adoption of a Code of Ethics were principal items on the agenda. Members were supposed to subscribe to the Code, and local societies desiring representation were required to consider it binding upon their members, too.

The first A. M. A. Code acknowledged its indebtedness to Percival, but it was shorter, and consisted of only three chapters. Their titles were "I. Of the Duties of Physicians to their Patients and of the Obligation of Patients to their Physicians. II. Of the Duties of Physicians to each other, and to the Profession at Large. III. Of the Duties of the Profession to the Public and of the Obligations of the Public

to the Profession." (Chauncey Leake's comment emphasizes the point which is probably in all your minds, "Sweet conceit of the medical moralists of the Fabulous Forties.")

Trouble began almost at once. At first, the complaints from the profession, while violent, led to no important actions. The principal difficulty was that the prohibition against "irregular" medical practitioners was applied to consultations between homeopath and allopath. Recognizing the faults of detailed codes, the New York state society, in 1882, offered a simplified and very brief system of ethics as a substitute for the national code. The next year, the society's delegates were refused admission to the A.M.A. convention. The first effect was the formation there of the "Society for the Prevention of the Re-enactment in the State of New York of the Present Code of Ethics of the American Medical Association." Next, the Society abandoned entirely a codified system of ethics. The majority of the group was ready to rely entirely on the theory that the profession should promise to discipline its members only for those things which "are comprehended under the commission of acts unworthy a physician and a gentleman". An unhealthy situation existed until 1903. Then, the "exclusive dogma" regarding consultation was omitted, and local groups were given interpretative privileges.

AMA Code Revised in 1949

Other revisions have occurred since 1903, the latest in 1949. The current Code bears the title "Principles of Medical Ethics". It covers about 21 pages and is divided into four chapters and one paragraph of conclusions. The headings now are: Chapter I. General Principles; Chapter II. Duties of Physicians to Their Patients; Chapter III. Duties of the Physician to Each Other and to the Profession at Large; Chapter IV. Duties of Physicians to the Public". You will note that a new first chapter has appeared. It takes up such matters as character, responsibility, groups and clinics, advertising, educational information, patents, commissions, rebates, secret remedies, and evasion of legal restrictions. These, and most sections of the succeeding chapters still can be traced to Percival's Code. The practice of physic apparently has not encountered so many new types of problems in 150 years as might be supposed.

Chapter II has been reduced to four sections. Chapter III is subdivided into Duties to the Profession (4 sections), Professional Services of Physicians to Each Other (3 sections), Duties in Consultations (8 sections), Duties in Cases of Interference (8 sections), and Compensation (6 sections). It is by far the longest unit of the present Code. This chapter puts much more emphasis on group discipline than other health service codes. Chapter IV has only 3 sections.

The Conclusion of the Code is a single paragraph. It states that the Principles are primarily for the good of the public, and that if the physician has the proper personal character and follows the Golden Rule, his life will be the best exemplification of ethical principles.

We have time only to refer very briefly to other professional codes. Their order of adoption is interesting, because it suggests the period at which the leaders of a profession saw a need for crystallizing their ideals into written forms. It also might suggest that mere formal adoption does not insure complete acceptance of the principle by all members of a profession.

About 300 Codes of American groups are now in existence. They run the gamut of activities from accounting to hairdressing, from hardwaremen to warehousemen. So far as I have been able to learn, three of the health service professions were the leaders in adopting national codes of ethics in this country. Your group was first, followed by Pharmacy, then by Veterinary Medicine. It is to be noted that the great majority of other organizations developed their codes during and following World War I. A similar but smaller wave of adoptions and revisions has followed World War II. Wars seem to have a way of stimulating the desire to serve mankind. Codes express that desire. We may note parenthetically that another important ethical outcome of the wartime activities of the professions, was the realization of the need for cooperation between the professions.

Much of this activity with respect to the adoption of codes should be attributed to the stimulus of the Rotary Clubs, some of the remainder to the American Academy of Political and Social Sciences. The Federal Trade Commission, particularly since World War II, has been urging the adoption of "Fair Trade Practice Rules" upon many industries. These, of course, involve ethical considerations. However, prior to this

program, the rulings of the Commission are interesting commentaries on what are regarded as good business practices.

Objectives Uniform

Now, gentlemen, why this historic sketch which could in a sense be duplicated for law, pharmacy, engineering, dentistry, etc.? What does it take to bring a profession to the stage of adopting, and *uniformly observing* these codes?

Some thirty years ago, Kohn (an architect) observed that the professions generally go through various stages of liberation from selfishness. Now, *that* is the basic meaning of a Code of Ethics—it prescribes the duties of the members of a group toward those outside the group—it is a release from selfishness. If you believe that traditional ethics is weakening, as Louise Eby said, then ethics based upon function—professional ethics—can and does bring to the general standard of the community a continuous and creative reinforcement.

The first stage of liberation from selfishness, according to Kohn, is the effort of the profession to protect its members from unfair competition and to improve the profession in the public consideration. This may sound paradoxical to the concept of unselfishness, but we must remember that confidence must be enjoyed to give a full measure of service. Confidence does not improve in an atmosphere of cutthroat competition. Hammurabi's code invoked the principle of *Lex talionis*, and it also meted out justice on a basis of social status, but it and the old Egyptian codes recognized the need for fair competition and improved standing in the public mind. This is implied in the Hippocratic Oath, and in others, and is stated in more than one form in Percival's Code. It is a part of every major professional code in force today, and of the Fair Trade Practice Rules.

The second step in the liberation of a profession from selfishness occurs when the members begin to consider the importance of their relations to each other. You have noted that the modern medical codes have in every case included a chapter "On the Duties of the Physicians to Each Other and to the Profession at Large". Substitute another noun for physician and you have substantially the equivalent in any other professional code. This stage is the most frequently noted. It also is the most abused—

for it readily degenerates into mere professional etiquette. Leake has gone so far as to call "Medical Ethics" a misnomer; he says that Percival and all his successors have written and thought mainly in terms of etiquette (group discipline?). Whether we go all the way with Leake or not, we cannot fail to see *some* reason for his statement. However, the point here is that this is a necessary stage in development, and if the professional man of the 20th Century puts undue stress on this relation and occasionally uses its injunctions to justify mere courtesies, or to cover malpractice, we must recognize and try to remedy this shortcoming.

A third necessary step in the process of liberation from selfishness, is the effort to prevent outside interference with the professions, legally or otherwise. The earliest Codes had one way of preventing interference with the medical men—the penalties for failure were stiff. Hippocrates' followers would make the would-be physician swear obedience to the Law and take the Oath in order to have any right to comment. Of course, they were *then* no longer outsiders. We are fighting another form of this problem today in the question of socialization of medical care. It is rather paradoxical that those who fight these proposals are accused of selfishness, when the opposite is, or can be, true.

The fourth step is the movement to improve standards of admission to practice. The Hippocratic Oath was intended to do that—or at least, to preserve the best of the old traditions. The mention of "irregular" practitioners by the Percival and early A.M.A. Codes was a sincere effort to encourage better standards. Usually, modern codes make no direct reference to admission requirements, other than a general statement concerning character.

Outline of Shortcomings

The last step is that one which interested me in this topic: Kohn has called it "—— the stage in which permanent importance is given to the relationship of the profession to the service which it may be expected to render—that is to say the stage where public needs are placed paramount to professional rights or even desires". Now, how can we be sure of attaining this goal in any profession? It is not logical to suggest that we can best advance this stage by bringing together

the various professions in some manner, or in some group organization, where in friendly intercourse, we can test our standards? Where we can receive help and benefit from our cousins in other professions? Where the validity of our own criteria may be checked in the light of friendly criticism from others?

I do not mean to belittle the fine work of some of the interprofessional councils. However, I feel that the usual Interprofessional Council has two shortcomings so far as the improvement of professional ethics is concerned. They are: Too narrow a base of membership, and the tendency to function almost solely for selfish benefits. This latter is a proper activity of the Intraprofessional Society.

The dentist, the teacher and the lawyer should know your Code in a general way, and you should know something of theirs. This will require a more broadly based group than any Interprofessional Council with which I am acquainted. Furthermore, such a group should meet regularly for the presentation of papers, and the holding of discussions thereon. A group of this type would soon be informing the public generally on many subjects of important and tangible value to the professions represented. They would go forth with facts, not as members of an organization, but as individuals, albeit men of some prestige, men who were not abroad to "grind their axes", but men who had been informed, weighed the facts, and made their decision. Their occasional comments in their daily contacts would be worth more than a dozen public relations programs. Many of the unjust criticisms which plague each profession would gradually disappear.

On the other hand, much greater appreciation of your standards would come about. Of course, nothing worthwhile is gained without some sacrifice. In this case, the sacrifice would be that of dropping a feeling of smugness, and of taking others into one's confidence to some extent. This should not hurt a truly professional man—it should, in fact, prove his right to be one.

Still further, I think we must be prepared to admit that professional Codes *are* rules of etiquette, in part; that their observance by the majority of a group requires the passage of time; and that the stages of liberation from selfishness overlap each other. Codes are written from an idealistic point of view, but are applied in an hedonistic manner. This, no doubt, is because the

responsibility, honor and prestige of the profession tend to exaggerate the actual level of idealism and inflate the egotism. Now, a man must make a living, even though he is willing to dedicate himself (apparently) to service—so he compromises. He takes an intermediate position between hedonism and idealism. We recognize this as a necessity. Our problem arises over the decision as to how far the compromise should go toward hedonism. It is customary for professional men, when called to account for their shortcomings, to excuse themselves on the basis of the “greatest good for the greatest number”—a frankly utilitarian viewpoint—or a calculated hedonism. It seems to me that no one can dispute the argument that this stand has some practical merit. But criticisms are leveled against a profession because its practitioners dilute their idealism with *too much* hedonism.

It is interesting to recall, too, that where a general increase in idealism is noted—a liberation from selfishness—the result is almost invariably an eventual increase in rewards, sometimes monetary, sometimes in other forms. Take for example the general custom of a businessman today in refunding on goods sold, or the physician who tries to be available to his patients as much as possible. Neither practice could be considered what we call “good business” in the old sense of the term, yet both the businessman and the doctor come up with a comfortable living, a knowledge that they have served to the best of their abilities, and both some day become a “man of the year”.

More Idealism Needed

Dr. E. C. Elliott said a few years ago, of Pharmacy—“It is a profession in solution, and the concentration varies from 100% down to about 1%.” He meant that too many Galenites showed too much hedonism in their makeup, that they should add some more of the beautiful crystals of idealism, to increase the concentration. Unfortunately, the same applies to other groups. From a recent personal experience, I submit that a certain pediatrician is diluting his golden professional ideals with too much of the silver (or is it brass?) of hedonism. Dentists, lawyers and others sometimes appear to do these things, too, in their special ways. What we must

learn, and practice, is to keep our professional ideals at the highest concentration consistent with the necessary comfort of our families.

A professional man is supposed to be characterized by the fact that he places a desire to serve above monetary gain. Is not that the only really fundamental difference between him and a plumber? Other differences are chiefly questions of degree. This is the reason the truly professional man has not increased his fees any more than absolutely necessary in this era of “phoney” prosperity. Those who have succumbed to the temptation to increase their charges in the same proportion as labor has done, are the major causes of the criticisms received in recent years.

To conclude the paper, and to emphasize certain points, allow me this brief recapitulation:

1. The term “Ethics” implies three basic concepts, value, law and duty. “Professional Ethics” is not exempted from any of these.

2. “Professional Ethics” should differ from other ethics principally in that it attempts to determine the proper application of these concepts by members of a small group toward those outside the group. It is suggested that the true stage of ethical development attained by the leaders of a profession may be better reflected by an analysis of a code, than by its date of adoption.

3. Codes of professional ethics should represent a high degree of “liberation from selfishness” on the part of *all* the members of a profession, but that is not necessarily true.

4. Codes are, and should be, written in idealistic terms. However, they are applied in an hedonistic fashion. This is a basic conflict inherent in any attempt to write a Code of Ethics, or to attain its general observance. It is suggested that there may be merit in giving wider publicity to the *contents* of a Code, with appropriate explanations. A broadly based interprofessional organization would be an important assistant both in spreading knowledge concerning ethical standards and in clearing up misunderstandings.

Finally, gentlemen, ethics and etiquette are two different words, of different meanings, words which no professional man should misuse or confuse.



ALL DOCTORS URGED TO ATTEND ACADEMY OF GENERAL PRACTICE SESSION

*A*LL MEMBERS of the Indiana State Medical Association are invited to attend the scientific sessions of the Annual Meeting of the Indiana Academy of General Practice, at the Antlers Hotel, Indianapolis, on Wednesday and Thursday, April 15 and 16. The scientific program is as follows:

Wednesday, April 15

- 9:00 A.M. (1) Registration begins, Mezzanine floor
(2) Technical Exhibits Open—Gold Room
- 9:00- 9:30—Teleclinic of A.A.G.P. Atlantic City meeting—Ball Room
- 9:30-10:00—Visit Technical Exhibits
- 10:00-10:50—"Hematology and the General Practitioner"
Joseph F. Ross, M.D., Boston
- 11:00-11:50—"General Obstetrics"
C. O. McCormick, Sr., M.D., Indianapolis
- 12:00- 1:30—Luncheon, Elks Club, Fourth floor
Speaker: Mr. C. Walter McCarty, Editor Indianapolis News
Subject: "Journalistic Obstetrics"
- 1:30- 2:00—Medical Movie—Ball Room
- 2:00- 2:50—"Management of Diabetes During Acute Complications"
Garfield G. Duncan, M.D., Philadelphia
- 3:00- 3:50—"Cyanosis and Vomiting in Newborn Babies"
Keith Hammond, M.D., Paoli, Indiana
- 4:00- 4:30—Visit technical exhibits
- 8:00 P.M. —Annual Founders Lecture
"Early Diagnosis of Cancer of G.I. Tract," John R. Paine, M.D., Buffalo
(Joint meeting with Indianapolis Medical Society)
Entrance to Ball Room off Mezzanine

Thursday, April 16

- 9:00- 9:30 A.M.—Teleclinic of A.A.G.P. Atlantic City Meeting—Ball Room
- 9:30-10:00—Visit Technical exhibits
- 10:00-10:50—"Myositis and Fibrisitis"—Ball Room
Frank Teague, M.D., Indianapolis
- 11:00-11:50—"Public Relations for the General Practitioner"
Mr. Leo E. Brown, Director Public Relations, American Medical Association
- 12:00- 1:30—Luncheon, Elks Club, Fourth floor
Speaker, Hon. George N. Craig, Governor of Indiana
Subject: "Our Indiana"
- 1:30- 2:30—"Panel on Therapeutics"—Ball Room
Participants:
John W. Hendricks, M.D., Indianapolis, "Eneuresis"
Glenn W. Irwin, M.D., Indianapolis, "ACTH and Cortisone in General Practice"
James H. Gosman, M.D., Indianapolis, "Common Skin Disorders"

- 2:30- 3:30—"Industrial Medicine and the G.P."
Emmett S. Lamb, M.D., Indianapolis (Commentary and color movie)
- 4:00- 4:50—"Movement of the Heart Valves and Cardiac Sounds"
H. L. Smith, M.D., Mayo Clinic, Rochester, Minnesota
(Color movie and sound, with commentary)
- 5:00- 5:30—Medical Movie
- 7:00 P.M. —Banquet—Ball Room
Dr. Kenneth McFarland, Topeka, Kansas, speaker

MANY INDIANA MEDICAL OFFICERS COMPLETING TERMS OF SERVICE

THE Military Manpower Committee of the Indiana State Medical Association through its chairman, Dr. John E. Owen, Indianapolis, has compiled the following list of medical officers from Indiana who recently have been released from service or will complete their tours of duty in the near future.* Each officer has been contacted by the headquarters office of I.S.M.A. by letter, welcoming him home and extending information and placement services to him.

The list includes: Capt. Gordon C. Walker, Jr., Terre Haute; Marshall E. Stine, Bremen; Capt. Robert D. Arnold, Indianapolis; Lt. (jg) Thomas J. Baker, Jr., Mt. Vernon; Lt. (jg) Clifford R. Sarver, Scottsburg; Lt. Gerald F. Ward, Indianapolis; Lt. William F. Oren, South Bend; Lt. (jg) Frank M. Sipes, Goshen; Lt. Kenneth E. Leasure, Elkhart; Lt. Edward I. Bolden, South Bend; Lt. George M. Buehler, Jeffersonville; Lt. Russell A. Eckert, Indianapolis; Lt. Joseph R. Hopkins, Hammond; Lt. Ronald H. Hull, Indianapolis; Lt. Theodore R. LeMaster, Indianapolis; Lt. Richard A. Theye,

Indianapolis; Lt. Richard R. Waite, Lafayette; Lt. Robert C. Ziss, Evansville; Lt. Lewis W. Knight, Indianapolis; Lt. Robert E. Vore, East Chicago; Lt. John A. Glaubke, Indianapolis; Lt. William B. King, Anderson.

Others listed are: Lt. Elmer W. Adams, Hammond; Lt. Robert J. Harvey, Indianapolis; Lt. Lunan W. Bromley, Kokomo; Lt. Everett D. Mattmiller, Mishawaka; Lt. Robert J. Stamper, Anderson; Lt. Dan B. Kahle, Indianapolis; Lt. Hubert C. Pirkle, Rockville; Lt. Frank M. Steele, Jr., Mishawaka; Maj. Charles Louis Easterday, Rome City; Capt. William Cecil Link, Bloomington; Capt. Elmer Dale Habegger, Berne; Maj. Joseph Carl Robinson, Evansville; Capt. Sidney R. Goldstone, Gary; Capt. Charles L. Lippoldt, Batesville; Lt. Niell M. Scully, Bloomington.

* Home addresses listed are those used at the time the officers entered service. Unreported changes in orders or the request of the officer in some cases to remain in service for a longer period may have caused inaccuracies in the above list, which was compiled from available official reports.



Deaths



Cyrus J. Clark, M.D., 52, clinical professor of cardiology and chairman of the post-graduate education program at Indiana University Medical Center, died in Riverview Hospital, Noblesville, January 22, from injuries sustained in an accident two days earlier. Returning to his home near Carmel, Hamilton county, after making house calls, Doctor Clark lost control of his car after a tire blew out.

A native and life resident of Hamilton county, Doctor Clark was graduated from Indiana University School of Medicine in 1923 and served his internship at General Hospital, Indianapolis. He was serving as chairman of the Executive Committee of the Indiana State Medical Association at the time of his death and had been a member of that committee during 1950, 1951 and 1952 when he also served as chairman. Through the years since 1933 when Doctor Clark held his first committee office in ISMA as secretary of the section on medicine, he had become increasingly active in association work. He had been chairman of many committees and sections, including the section on medicine, committees on business instructional courses, graduate education, pneumonia and scholarships. He was a member of the liaison committees which met with the Indiana Crippled Children's Bureau and the State Department of Public Welfare. Doctor Clark had been a delegate to the Indiana State Medical Association's annual session and served as Seventh District Councilor from 1936 to 1944.

The Indianapolis physician, who was a specialist in internal medicine, commanded the 32nd General Hospital unit, sponsored by the I. U. Medical Center during World War II, holding the rank of colonel. He served with the unit in Europe.

Roy Egbert, M.D., Indianapolis general practitioner for the last 45 years, died January 17 in Methodist Hospital, Indianapolis. He was 70 years old, a native of Morgan county and graduate of the State College of Physicians and Surgeons, Indianapolis, in 1907. Doctor Egbert was a member of Indianapolis Medical Society, Indiana State and American Medical Associations.

LaFayette Glenn, M.D., Ramsey physician for 44 years, died January 19 in his home after a series of heart attacks earlier in the day. He was 76 years old but had been in active practice until the day of his death. Born in 1876 in Valeene, he had taught school in Orange county before entering the Hospital College of Medicine in Louisville from which he was graduated in 1903. In 1904 he began the practice of medicine in Crandall and in 1910 established his practice in Ramsey. He was a member of Indiana State and American Medical Associations and the Harrison County Medical Society.

Edward M. Young, M.D., 83, died January 17 in the Veterans Hospital, Indianapolis, where he had been taken two months earlier from his home in Sheridan. He had practiced in Sheridan since 1908, retiring two years ago. Doctor Young not only served Hamilton county as a physician but had been active for many years in church, library and lodge work. Born in Illinois in 1869, he was a 1906 graduate of the Illinois Medical College in Chicago and then came to Indiana establishing practice in Jolietville that year and moving to Sheridan two years later. During World War I he served as a captain in the Medical Corps. He was the father of George M. Young, M.D., Gary. Doctor Young was a member of Hamilton County Medical Society and the state and national medical associations.

Jon Kelly, M.D., LaPorte specialist in anesthesiology for many years, died January 20. He was 76 years old. An 1898 graduate of the Cen-

tral College of Physicians and Surgeons, Indianapolis, Doctor Kelly served in 1922 and 1923 as secretary of the LaPorte County Medical Society. In 1936 he was a member of the committee on expert testimony of the state association and served as delegate to the state convention from 1934 through 1949 with the exception of 1945. He was a member of county, state and national medical organizations.

Sumner A. Furniss, M.D., 78, prominent Negro physician in Indianapolis for more than 50 years, died in General Hospital January 18 from the effects of a fractured hip suffered in a fall at his home December 27.

Born in Jackson, Mississippi, Doctor Furniss came to Indianapolis at nine years of age with his parents who were teachers in the public schools. Completing his medical education in 1894 at the Medical College of Indiana, he became the first Negro intern at City Hospital and while there gained recognition for work done during a smallpox epidemic. Although devoted to his medical practice, Doctor Furniss contributed much to the progress of his race. He was a founder of the Senate Avenue Y.M.C.A., held the highest office in Masonic orders for 25 years, served as the first Negro city councilman in Indianapolis from 1917-21 and at the time of his retirement two years ago was a member of the Indianapolis Board of Health. He was a member of the Indianapolis Medical Society, a senior member of the Indiana State Medical Association and a member of American Medical Association.

Louis F. Ross, M.D., 72, Richmond, died January 29. Born in Richmond, Doctor Ross returned to his native city after graduation from the University of Michigan Medical School, Ann Arbor, and established practice in 1907. In 1923 he became medical superintendent of the Richmond State Hospital where he remained for 10 years, resuming his private practice in 1933. Doctor Ross was a former chairman of the staff of Reid Memorial Hospital, Richmond, and assistant surgeon of the Pennsylvania railroad for several years. He was the father of Dr. Richard Starr Ross, instructor at Harvard University Medical School. Doctor Ross, a spe-

cialist in internal medicine, was a member of American Psychiatric Association, the Wayne-Union County Medical Society and the state and national associations.

Max A. Bahr, M.D., 78, who for 54 years served as superintendent of Central State Hospital and was widely known as a specialist in psychiatry, died January 24 in his home in Thorntown. He had been in retirement since 1950 and seriously ill for 10 months. Born in Indianapolis in 1874, he attended Central College of Physicians and Surgeons in Indianapolis, receiving his degree in 1896 and his career with the state mental institution began at once. His length of service with one hospital is thought to be unequalled. He had also served as professor of neurology and psychiatry at Indiana University School of Medicine and was the author of several volumes on neuropsychiatric subjects and a frequent contributor to medical journals.

Doctor Bahr served as chairman of the committee on expert testimony of the Indiana State Medical Association in 1935 and 1936 and was a member of the committee on mental health from 1937 through 1946. He was Marion county delegate to the ISMA for four years.

Doctor Bahr held membership in the American Psychiatric Association, the Central Neuropsychiatric Association, Indianapolis Medical Society, and the Indiana State and American Medical Associations. He had belonged to the national association for 50 years.

Harry A. Jacobs, M.D., 72, died February 3 in his Indianapolis home. A practicing physician for more than 50 years, Doctor Jacobs specialized in gynecology. He was a 1901 graduate of the Medical College of Indiana and interned at City Hospital, Indianapolis. In addition to his memberships in Indianapolis Medical Society, Indiana State and American Medical Associations, Doctor Jacobs was active in many Jewish organizations.

Claude A. Robison, M.D., 60, Frankfort physician since 1919, died February 2 in his home after being ill since August. Born in Clin-

ton county in 1892, he was a 1918 graduate of the Indiana University School of Medicine. After establishing his Frankfort practice, Doctor Robison did postgraduate work in Chicago, Denver and in Vienna. He was a specialist in ophthalmology, otology, laryngology and rhinology. Doctor Robison was a member of county, state and national medical organizations.

Monroe L. Ploughe, M.D., 88, died February 7 in an Elwood nursing home where he had been seriously ill for two weeks. Born in Tipton county in 1864, he obtained his M.D. degree from the Medical College of Indiana in 1892 and established practice in Goldsmith where he remained for four years. Since 1896 Doctor Ploughe had practiced continuously in Elwood until his retirement. He had served as physician and surgeon for many years for several Elwood industries and utilities. Elwood's oldest doctor, Doctor Ploughe was associated with several phy-

sicians before joining his son, Dr. Ralph Ploughe, in practice in 1931.

Active in both civic and medical organizations, Doctor Ploughe was a member of Madison County Medical Society and the Indiana State and American Medical Associations. He became a member of the Fifty Year club in 1942.

John A. Pfaff, M.D., 82, died suddenly February 7 while returning by bus to his Indianapolis home from his office. A native of Indianapolis where he was born in 1870, Doctor Pfaff was an 1898 graduate of the Medical College of Indiana. He was a member of the staffs of Coleman, St. Vincent's, General, Robert W. Long and Methodist hospitals and was emeritus professor of gynecology at Indiana University School of Medicine.

Doctor Pfaff had practiced for 54 years, was a 50-year member of Indianapolis Medical Society and the Indiana State Medical Association.



News Notes

Indiana's Communicable Disease Record Good

Indiana continued in 1952 with its good communicable disease record with no cases of smallpox reported for the fourth year and the incidence of diphtheria 355 cases below the five-year average and 49 cases fewer than the 88 reported in 1951.

This is shown by the morbidity report of the Indiana State Board of Health which is issued weekly in cooperation with local health agencies. Dr. Albert L. Marshall, director of the Division of Communicable Disease Control, emphasized the fact that the reporting of the communicable diseases by the city and county health officers only indicates the trend of the disease, as not every case is reported to the health officers.

Whooping cough showed a drop in incidence, being 612 cases below the number reported last year, but an increase was shown in the number of cases of chickenpox, measles, poliomyelitis and mumps reported.

In line with the normal cycle as expected every four years, measles showed the largest jump with 3,801 more cases reported last year as compared to the preceding year of 4,548 cases. A total of 1,397 more cases of mumps was recorded and this was 1,880 over the average. Chickenpox was only 221 cases more than the five-year median, but totaled 1,205 more than occurred in 1951.

Poliomyelitis followed the national trend. Dr. Marshall pointed out that although there was an increase in the number of cases reported, this should not be regarded as epidemic, as the cases were widespread throughout the state and not concentrated in local areas.

Dr. William J. Little, who has just completed a rotating residency at Indiana University Medical Center and the Veterans Administration hospital, is now associated with Drs. Beeler, Collins and Beeler, 712 Hume Mansur Building, Indianapolis, in the practice of radiol-

ogy. Doctor Little, a 1945 graduate of the Indiana University School of Medicine, was formerly in general practice at Bicknell.

Dr. Herman L. Hirsch, who is now serving his internship in St. Vincent's Hospital, Indianapolis, plans to open an office in Mt. Vernon on completion of his internship in July. He will occupy offices vacated when Dr. G. E. Dunigan, Mt. Vernon dentist, was recalled to naval duty. Dr. Hirsch is a World War II veteran and received his M.D. at St. Louis University School of Medicine. He is a native of Poseyville.

Dr. and Mrs. C. R. Herd, who were injured in an automobile accident near Angola, October 25, have been taken to their Peru home from Methodist Hospital, Indianapolis, where they have been receiving treatment. Both Doctor and Mrs. Herd are improved.

Dr. Ralph Dreyer, who has practiced in Knightstown since 1940 when he became physician for the Indiana Soldiers' and Sailors' Children's Home, has reported to Great Lakes Naval Training station for duty. His Knightstown office has been closed.

Dr. Jack E. Shields, Brownstown, has been named president of the staff of Jackson County Hospital for the coming year. **Dr. Robert L. Peden**, Seymour, will be vice-president. **Drs. W. H. Shortridge, Charles E. Gillespie** and **Joseph M. Black**, all of Seymour, were named members of the executive committee for three years.

The annual meeting of the **Indiana Roentgen Society** will be held in the Indianapolis Athletic Club at 2 o'clock, Sunday, May 3. Principal speaker will be Dr. B. R. Kirklin, Mayo Clinic, Rochester, Minnesota. Announcement was made by Dr. John A. Robb, secretary.

SAMA Gets Its 1953 Program Under Way

Strengthening its position as the voice of its 15,000 members, the House of Delegates of the Student American Medical Association set an accelerated program in motion during its second annual convention in December in Chicago.

Chief proposal of the delegates from 50 of SAMA's 59 chapters called for a point system in doctor draft legislation to consider all previous military service, regardless of branch or rank. Another resolution asked for a synchronization of doctor draft calls with hospital training programs so that young doctors will not experience unnecessary delay in resumption of their training following military service. The House also urged its constituent chapters to invite officers and staff members from organized medicine to address local meetings so that students will be kept informed on current medical activities.

The convention attracted more than 225 delegates, alternates and guests. The next convention is scheduled for June.

The Medical Education for National Defense (MEND) program will continue during the 1953-54 academic year on a broadened scale in selected medical schools, Colonel Floyd L. Wergeland, MC, Chief of the Education and Training Division in the Office of the Army Surgeon General, reported recently.

Five medical schools are conducting the program during the current academic year on an experimental basis in cooperation with the Defense Department and other Federal agencies. Colonel Wergeland said both the faculty and students of participating schools had cooperated enthusiastically in the effort to incorporate military and civil defense aspects of medical subjects into the regular curricula of these institutions.

The schools selected by the Association of American Medical Colleges for the pilot study were the University of California, the University of Illinois, the University of Buffalo, Cornell University and Vanderbilt University. Other colleges of medicine will be added to the list as the success of the initial experiment is fully established and norms for the operation of the plan are worked out.

The MEND program provides that subjects related to military medicine and disaster relief be introduced into as many first-year medical courses as possible.

The Sixth Annual Postgraduate Course in Diseases of the Chest sponsored by the American College of Chest Physicians, Pennsylvania Chapter and the Laennec Society of Philadelphia, will be presented at the Bellevue Stratford Hotel, Philadelphia, March 23-27, 1953.

This course will emphasize the recent developments in all aspects of the diagnosis and treatment of chest disease. The course is open to all physicians, however the number of registrants will be limited.

The tuition fee is \$50 and applications will be accepted in the order in which they are received. This course has been approved for credits by the American Academy of General Practice. Applications should be sent to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

Societies May Co-Sponsor Interesting TV Films

Three films produced by the Metropolitan Life Insurance Company recently were cleared for use on educational and public service television programs. "Once Upon a Time"—a 10-minute animated cartoon dealing with state and highway safety "Proof of the Pudding"—a 10-minute dramatic presentation showing the essentials of good nutrition and the relation between diet and health; "Be Your Age"—an 11½-minute drama depicting the middle-aged, over-weight "John's" recovery from a heart attack and his subsequent adjustment to living with a handicapped heart. The films are available to county medical societies who desire to co-sponsor these films on television. They may be secured from Metropolitan Life Insurance Company, 1 Madison Avenue, New York 10, N. Y.

Average Doctor Has More Patients Now

The average U. S. physician in private practice works a 58 hour week and sees 28 patients in a typical day. His patient load has increased 12 per cent in the last four years.

These figures are revealed in the February issue of *Medical Economics*, national business magazine for doctors. The magazine is publishing the results of a nationwide survey it made recently among its 134,000 M.D.-readers.

Local Societies Should Plug "Your Doctor" Film

Local medical societies can improve their "public relations rating" in the community by booking the "Your Doctor" film for non-theatrical showings at society meetings or to PTAs, schools, churches and other groups interested in health. Sixteen millimeter prints of this 15-minute sound film now are available on loan from Modern Talking Picture Service, Inc., 45 Rockefeller Plaza, New York 20, N. Y. Produced as a documentary, this film points up ways in which the medical profession has helped to bring better medical care to everyone. During 1952 more than 12 million Americans viewed the movie in over 5,000 commercial theaters throughout the country. It is hoped that medical societies will continue to promote the film locally.

Eli Lilly and Company, which discovered and developed the new wide-range antibiotic "Ilotycin" (Erythromycin, Lilly), has announced, effective January 5, 1953, a 26 per cent reduction in its price. At the same time, Lilly's reduced prices on certain items in its penicillin, streptomycin, and dihydrostreptomycin line.

Commenting on the "Ilotycin" price reduction, J. K. Lilly, president of the company, said: "We have every reason to hope that 'Ilotycin' will repeat the price history of most new drugs. The initial price reflects the cost of extensive research and development and also a company's limited experience in producing the new item. Under our American process of competition, any manufacturer must look sharply at his price just as soon as he develops better yields and more efficient means of production."

Dr. Harold B. Houser, who received his M.D. from Indiana University in 1944, was one of sixteen persons awarded fellowships to pursue original basic research in arthritis and the rheumatic diseases by the Arthritis and Rheumatism Foundation in New York recently. Dr. Houser was awarded a grant of \$6,000 to study the development of an improved method for detecting type specific antibodies for Group A beta-hemolytic streptococci at the State University of New York at Syracuse.

An advanced course in autoradiography and three basic courses in radioisotope techniques are course offerings of interest to medical and biological personnel planned this spring and summer by the Special Training Division of the Oak Ridge Institute of Nuclear Studies.

The autoradiography course will be held from June 15-25, and basic courses of four weeks duration will begin on June 8, July 6, and August 10.

Application forms and additional information may be obtained from the Special Training Division, Oak Ridge Institute of Nuclear Studies, P. O. Box 117, Oak Ridge, Tenn.

Special Health Services In Industry Discussed

Current trends in direct service plans (health services in industry provided through salaried or panel physicians) . . . ways and means of maintaining high standards of medical service directly to certain groups of industrial workers . . . were aired at an informal conference on Direct Service Plans. This meeting, sponsored by the Committee on Medical Care for Industrial Workers—a joint committee of the AMA's Council on Medical Service and the Council on Industrial Health—was held in January during the Annual Congress on Industrial Health.

Viewpoints of labor, management and the medical profession were expressed as more than 50 representatives of plans sponsored by labor and industry sat down with representatives of state and county medical societies. Many suggestions regarding future developments in programs designed to render medical care through voluntary methods were presented for study and future discussion.

Psychosomatic problems in the aged will be the general topic of a panel discussion which will be the third of a current series of Psychosomatic Forum meetings in the Conference room of Veterans hospital. The discussion is scheduled for 8 p. m., Tuesday, April 7. Dr. William D. Province will serve as moderator and others participating will be: Dr. William F. King, Dr. James H. Gosman, Dr. James S. Browning and Dr. T. F. Schlaegel, Jr.

TB Symposium for GP's in Saranac Lake Next Summer

The Second Annual Tuberculosis Symposium for General Practitioners will be held in Saranac Lake, N. Y., from July 13 through 17, 1953. It is approved by the American Academy of General Practice for 26 hours of formal credit for its members.

The Symposium is sponsored by the Saranac Lake Medical Society and the Adirondack Counties Chapter of the New York State Academy of General Practice. The registration fee is \$40 for A.A.G.P. members and \$50 for non-members. Registration is limited to 100 doctors.

Many physicians who attended last year's symposium brought their families to Saranac Lake. So that families might have use of the car to enjoy the many recreational facilities of the Adirondack Mountains, free bus transportation was provided for physicians from Saranac Lake to the various meeting places. This practice will be followed again this year.

Complete information concerning this program can be obtained by writing: Richard P. Bellaire, M.D., Tuberculosis Symposium for General Practitioners, P. O. Box 707, Saranac Lake, New York.

The 31st annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held on August 31, September 1, 2, 3 and 4, 1953, inclusive, at the Palmer House, Chicago, Ill. Scientific and clinical sessions will be given on the days of August 31 and September 1, 2 and 3. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

Dr. and Mrs. David A. Bickel, South Bend, left February 6 for Sao Paulo, Brazil, to attend the Inter-American session of the American College of Surgeons. Doctor Bickel will also visit hospitals and clinics in Buenos Aires, Argentina, Santiago, Chile and Lima, Peru. Dr. and Mrs. Bickel will return after visiting Guatemala and Panama.

WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. Hubert T. Goodman, Terre Haute
President-Elect—Mrs. Burleigh Matthew, Indianapolis
Corresponding Secretary—Mrs. B. M. Merrell, Rockville
Recording Secretary—Mrs. Charles Richardson, Rochester
Treasurer—Mrs. J. M. Sullivan, Terre Haute
Publicity—Mrs. F. M. Gastineau, Indianapolis

Bloomington is the place, April 22nd and 23rd the time, the Woman's Auxiliary of Owen-Monroe Counties the hostesses for the House of Delegates meeting of the Woman's Auxiliary to the Indiana State Medical Association. Mrs. Herbert T. Goodman, state president, Mrs. Eldred Hardtke, local president, and Mrs. Dillon Geiger, chairman, and a large committee have been making plans for the meeting.

Streamlined business meetings, good speakers and outstanding entertainment (excerpts from Jordan River Revue Wednesday night) plus a chance to enjoy life on the University Campus should make this an enjoyable experience for all. Contact your local president if you wish to attend as she has detailed instructions about reservations. Deadline for reservations is April 5, 1953.

Indiana University News Notes

The new George A. Ball Visiting Professorship in Surgery was inaugurated at the Indiana University School of Medicine on February 13 by Dr. Paul C. Bucy, Professor of Neurology and Neurosurgery at the University of Illinois. Doctor Bucy will visit the campus weekly for several months, conducting a conference on current neurosurgical programs; a neurological and neurosurgical teaching clinic; and, with the cooperation of the staff, will present a neurological and neurosurgical clinical pathological conference. Physicians of the state have been invited to attend.

Others to occupy the Visiting Professorship during the present semester will include: Dr. R. Eustace Semmes, Professor of Neurological Surgery, University of Tennessee, the week of April 12; Dr. Percival Bailey, Professor of Neurology and Neurological Surgery, University of Illinois, the week of May 12; and Dr. Francis D. Ingraham, Professor of Neurological Surgery, Harvard Medical School, at a date to be announced.

The Visiting Professorship was established in recognition of the services of Mr. George A. Ball, Muncie industrialist and philanthropist, as a charter member of the James Whitcomb Riley Memorial Association which sponsored the Riley hospital for children, and as a former trustee of Indiana University.

Physicians from all parts of Indiana were registered for the annual postgraduate Symposium on the Heart, at the Indiana University School of Medicine, February 10, with Dr. Paul D. White, Harvard Medical School; Dr. Walter T. Zimdahl, University of Buffalo, and Gen. George E. Armstrong, Surgeon General USA, as speakers. The speakers formed a panel for a roundtable discussion of heart problems in the evening, the discussion being heard by telephone at meetings of county medical societies.

Cancer of the Cervix is the topic for the sixth annual postgraduate Symposium on Malignancy being presented March 4 at the Indiana University School of Medicine. Participants in the program include: Dr. A. N. Arneson, Washington University School of Medicine; Dr. Alexander Brunschwig, Cornell University; Dr. David N. Danforth, Northwestern University; Dr. John L. McKelvey, University of Minnesota; Dr. Norman F. Miller, University of Michigan; Dr. Daniel G. Morton, University of California; Dr. Emil Novak, and Dr. Richard W. Te Linde, both of Johns Hopkins University.

ENT specialists from a number of states have registered for the 33rd annual Anatomical and Clinical Course in Otorhinolaryngology being presented March 30-April 14, by the staff of the Indiana University School of Medicine. This is a limited enrollment course, requiring advance registration.

Special Announcement

An advanced workshop for Medical Record Librarians will be held at the Indiana University Medical Center in Indianapolis, April 27-May 1, 1953.

Requirements for registration for the workshop are that the applicants be registered record librarians, be employed in hospitals of 200 or more beds, and have an office staff of at least five under their supervision. Registration will be limited and applications must be on file by April 1.

Further information can be obtained by writing to Miss Doris Gleason, R.R.L., Executive Secretary, American Association of Medical Record Librarians, 510 North Dearborn street, Chicago 10, Illinois.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

The Council

January 25, 1953.

The Council of the Indiana State Medical Association convened for its mid-winter meeting at 10 a. m. Sunday, January 25, 1953, in Parlor No. 1 of the Columbia Club, at Indianapolis, with Dr. Wemple Dodds, chairman, presiding.

Roll call showed the following present:

Councillors:

First District-----Herman T. Combs, Evansville
 Second District-----A. G. Blazey, Washington
 Sam I. Rotman, Jasonville, alternate
 Third District-----William H. Garner, New Albany
 Fourth District-----Charles Overpeck, Greensburg
 Fifth District-----M. C. Topping, Terre Haute
 Sixth District-----W. U. Kennedy, New Castle
 Seventh District-----Roy A. Geider, Indianapolis
 Don E. Wood, Indianapolis, alternate
 Eighth District-----T. R. Hayes, Muncie, alternate
 Ninth District-----Wemple Dodds, Crawfordsville
 H. E. Klepinger, Lafayette, alternate
 Tenth District-----J. Robert Doty, Gary
 Eleventh District-----Not represented
 Twelfth District-----M. B. Catlett, Fort Wayne
 Thirteenth District---Kenneth L. Olson, South Bend

Officers:

Paul D. Crimm, Evansville, president
 Wm. Harry Howard, Hammond, president-elect
 Roy V. Myers, Indianapolis, treasurer
 Frank B. Ramsey, Indianapolis, editor of THE JOURNAL
 A. W. Cavins, Terre Haute, associate editor of THE JOURNAL
 Lall G. Montgomery, Muncie, associate editor of THE JOURNAL
 W. L. Portteus, Franklin, member, Executive Committee
 Albert Stump, attorney
 James A. Waggener, executive secretary

Guests:

Cleon A. Nafe, Indianapolis, A.M.A. delegate
 Robert A. Rang, Washington, A.M.A. alternate
 Harold C. Ochsner, Indianapolis, and J. William Wright, Indianapolis, co-chairmen, Legislative Committee
 Dillon Geiger, Bloomington, member, Legislative Committee
 Clyde G. Culbertson, Indianapolis, chairman, Committee on Scientific Work
 John Palm, Brazil, member, Committee on Veterans' Affairs and Rehabilitation
 Robert J. Amick, field secretary

By consent, the minutes of the Council meetings held at Indianapolis on October 28 and 30, 1952, were approved as printed in the December, 1952, issue of THE JOURNAL.

Reports of Councillors

Councillors reported district meetings scheduled as follows for the coming year:

First District-----April 12, 1953 (tentative)
 Second District-----
 Third District-----
 Fourth District-----Columbus, -----
 Fifth District-----
 Sixth District-----Connersville, April 30, 1953
 Seventh District-----
 Eighth District-----Muncie, May 20, 1953
 Ninth District-----Noblesville, May 27, 1953
 Tenth District-----
 Eleventh District----Delphi, May 20, 1953
 Twelfth District-----Fort Wayne, May 21, 1953
 Thirteenth District---South Bend, November 18, 1953

Reports of Officers

Dr. Roy V. Myers, treasurer, announced that since the first of the year, upon the advice of bank officials, the association had invested \$30,000 from the General Fund in short-term government bonds, due June 1. This type of security was chosen with the thought that bonds paying a higher rate of interest might be available later on in 1953.

The report compiled by George S. Olive and Company, certified public accountants, follows:

Treasurer's Report

January 27, 1953.

The Council,

Indiana State Medical Association,
 Indianapolis, Ind.

Gentlemen:

We have examined the accounts and financial records of the Indiana State Medical Association as of December 31, 1952, and the statements of income and expense and fund balances for the year then ended, on a cash receipts and disbursements basis. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying statement of assets, all funds, and related statements of income and expense, on a cash receipts and disbursements basis, present fairly the position of the Indiana State Medical Association at December 31, 1952, and the results of its operations for the year then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Yours very truly,

GEO. S. OLIVE & Co.,
 Certified Public Accountants.

Exhibit A	
INDIANA STATE MEDICAL ASSOCIATION	
Analysis of Increase in Assets, All Funds, Year Ended December 31, 1952	
TOTAL ASSETS, DECEMBER 31, 1952—ex-	
hibit B -----	\$174,728.37
TOTAL ASSETS, DECEMBER 31, 1951----	119,223.28
NET INCREASE -----	\$ 55,505.09

Arising from the following sources:	
Excess of operating cash receipts over operating cash disbursements, year ended December 31, 1952:	
General fund—exhibit C:	
Receipts ---\$142,465.34	
Disburse-	
ments --- 113,731.34	
	28,734.00
Add: Pur-	
chase of	
bonds ----- 35,000.00	
	\$63,734.00
The Journal of	
the Indiana	
State Medi-	
cal Associa-	
tion — ex-	
hibit D:	
Receipts -- 39,374.21	
Disburse-	
ments --- 48,980.02	
	(9,605.81)
Medical De-	
fense fund—	
exhibit E:	
Receipts --- 4,827.55	
Disburse-	
ments --- 4,450.65	
	376.90
Add: Pur-	
chase of	
bonds --- 1,000.00	
	1,376.90
NET INCREASE -----	\$ 55,505.09

Exhibit B	
INDIANA STATE MEDICAL ASSOCIATION	
Statement of Assets, All Funds, at December 31, 1952	
GENERAL FUND:	
Cash on deposit—Exhibit C----	\$69,449.55
Petty cash fund -----	1,000.00
Investments:	
U. S. Treasury	
bonds ----- \$ 5,000.00	
U. S. Savings	
bonds ----- 71,000.00	
	76,000.00
Total General Fund -----	\$146,449.55
THE JOURNAL OF THE INDI-	
ANA STATE MEDICAL AS-	
SOCIATION:	
Cash on deposit—Exhibit D---	4,960.47

MEDICAL DEFENSE FUND:	
Cash on deposit—Exhibit E----	4,318.35
Investments:	
U. S. Treasury	
bonds ----- 5,000.00	
U. S. Savings	
bonds ----- 14,000.00	
	19,000.00
Total Medical Defense Fund	23,318.35
TOTAL ASSETS, ALL FUNDS—Exhibit A	\$174,728.37

Exhibit C			
INDIANA STATE MEDICAL ASSOCIATION			
Comparative Statement of Cash Receipts and Dis-			
bursements, Years Ended December 31, 1952, and			
December 31, 1951			
GENERAL FUND			
	Year Ended		
	Dec. 31,	Dec. 31,	Increase
	1952	1951	(Decrease)
CASH BALANCE			
AT			
BEGINNING OF			
YEAR -----	\$40,715.55	\$ 5,533.51	\$35,182.04
RECEIPTS:			
Membership dues -	115,850.00	115,370.00	480.00
Income from			
exhibits -----	14,316.00	14,675.00	(359.00)
Interest income ---	1,507.50	1,172.50	335.00
Proceeds from ma-			
tured bonds -----	-----	4,000.00	(4,000.00)
Egbert Scholarship			
fund -----	100.00	200.00	(100.00)
Centennial book			
fund -----	2.50	14.45	(11.95)
Miscellaneous in-			
come -----	-----	14.00	(14.00)
Instructional			
courses -----	689.34	-----	689.34
Transferred from			
The Journal of			
the Indiana State			
Medical Associa-			
tion -----	10,000.00	-----	10,000.00
Total receipts			
—Exhibit A—	\$142,465.34	\$135,445.95	\$7,019.39

BEGINNING BAL-			
ANCE PLUS CASH			
RECEIPTS -----	183,180.89	140,979.46	42,201.43
DISBURSEMENTS:			
Transfer of appli-			
cable portion of			
dues to The Jour-			
nal of the Indiana			
State Medical As-			
sociation -----	11,019.00	10,896.00	123.00
Medical Defense			
fund—Exhibit E--	4,348.75	4,318.75	30.00
Purchase of			
securities -----	35,000.00	4,000.00	31,000.00
Headquarters'			
office expense --	26,726.12	21,155.03	5,571.09
Publicity			
committee -----	906.88	1,703.55	(796.67)
Public policy ----	1,608.29	2,374.83	(766.54)
Council -----	1,480.84	1,563.46	(82.62)
Officers -----	2,712.09	1,893.40	818.69
Annual session ---	13,164.98	11,800.25	1,364.73
Standing			
committees -----	5,957.07	3,170.73	2,786.34

Special committees	2,929.68	5,814.48	(2,884.80)
Federal insurance contributions tax	239.77	242.37	(2.60)
Indiana unemployment compensation and excise tax	431.92	421.31	10.61
Fifty-year club	245.04	324.08	(79.04)
Increase in petty cash fund		500.00	(500.00)
Woman's Auxiliary to I.S.M.A.	298.77	77.13	221.64
General practitioner award	476.04	58.46	417.58
A.M.A. Coordinating Committee	6,186.10	29,950.08	(23,763.98)
Total disbursements—Exhibit A	113,731.34	100,263.91	13,467.43

**CASH BALANCE AT
END OF YEAR \$ 69,449.55 \$ 40,715.55 \$ 28,734.00**

Exhibit D**INDIANA STATE MEDICAL ASSOCIATION**

**Statement of Cash Receipts and Disbursements,
Year Ended December 31, 1952**

**THE JOURNAL OF THE INDIANA STATE
MEDICAL ASSOCIATION**

BALANCE, JANUARY 1, 1952 --- \$14,566.28

RECEIPTS:

Subscriptions—members—	
Exhibit C	\$11,019.00
Subscriptions—non-members	469.50
Advertising	27,139.45
Collections on accounts receivable	445.78
Single copy sales	152.50
Electrotypes	29.84
Sale of civil defense reprints	48.35
Miscellaneous	69.79

Total receipts—Exhibit A ----- 39,374.21
53,940.49

DISBURSEMENTS:

Salaries	8,298.13
Printing	26,563.85
Office postage	258.30
Journal postage	640.55
Advertising commissions	167.86
Electrotypes	956.58
Press clippings	120.20
Office supplies	570.38
Rent	480.00
Electricity	32.27
Telephone and telegraph	241.06
Federal insurance contributions	124.08
Indiana unemployment compensation and excise	248.19
Art work	88.27
Transfer to general fund	10,000.00
Miscellaneous	190.30

Total disbursements—

Exhibit A ----- 48,980.02

BALANCE, DECEMBER 31, 1952—Exhibit H \$4,960.47

Exhibit E**INDIANA STATE MEDICAL ASSOCIATION**

**Statement of Cash Receipts and Disbursements,
Year Ended December 31, 1952**

MEDICAL DEFENSE FUND

BALANCE, JANUARY 1, 1952 --- \$3,941.45

RECEIPTS:

Transfer of applicable portion of dues from the general fund—	
Exhibit C	\$ 4,348.75
Interest income	478.80

Total receipts—Exhibit A ----- 4,827.55

8,769.00

DISBURSEMENTS:

Malpractice fees	1,475.00
Attorney fees	1,882.50
Treasurer's bond	37.50
Purchase of U. S. Savings bond	1,000.00
Miscellaneous	55.65

Total disbursements—Exhibit A ----- 4,450.65

BALANCE, DECEMBER 31, 1952—Exhibit B \$4,318.35

Dr. Frank B. Ramsey, editor of THE JOURNAL, said, "We are a little short on editorials that are reprinted in our column, 'The Fourth Estate Looks at Medicine.' I would like to ask the councilors to clip and send in any editorials which they see in their local papers either for or against medicine. We will be very pleased to receive these."

By consent, the Council approved the binding of four volumes of THE JOURNAL for 1953.

1953 Annual Session at French Lick

1. *Dates* are Monday, Tuesday and Wednesday, October 19, 20 and 21, 1953.

2. *Report of Committee on Convention Arrangements.* The secretary read the following letter from Dr. E. L. Fitzsimmons of Evansville, chairman:

"This is a report to you and the Council on the progress of the arrangements for the Indiana State Medical Association convention for October, 1953.

"Our budget for the convention has been prepared and has been accepted by the Executive Committee at \$5,750.00. As chairman, I met with you and Mr. Art Tiernan and Dr. Paul Crimin at French Lick in November to consider the possibilities for the stage, etc.

"Several members of my committee have met with me and we have met twice with McGuire and Paxton, of Indianapolis, who will help us with our entertainment.

"The present plans are as follows:

"On Monday night, the men will have a buffet dinner and at the same time the women will occupy another room having their usual Monday night dinner. Following this, the men and their wives will meet for a joint entertainment. At that time, it is anticipated that a good program will be arranged in conjunction with the committee from the Woman's Auxiliary. On Tuesday night, the President's night, we have planned a very high-class vaudeville show. Four tentative acts have been arranged for the evening which will occupy between one and one-half and two hours of show. On Wednesday night, following the annual dinner and various speeches, we will have a good dance band for

those who care to dance. Other details such as the menus, etc., will be arranged closer to the convention time."

3. *Budget.* On motion of Drs. Geider and Olson the Council approved the action of the Executive Committee in allowing a budget of \$5,750.00 to the Committee on Convention Arrangements for the 1953 convention.

4. *Tentative outline of program:*

Sunday, October 18, 1953	
12:00 noon.	Executive Committee meeting.
3:00 p. m.	Council meeting.
6:30 p. m.	Meeting of House of Delegates. (Dinner meeting.)
Monday, October 19, 1953	
8:00 a. m.	Annual golf tournament.
9:00 a. m.	Annual trap and skeet shoot.
10:00 a. m.	Editorial Board meeting.
11:00 a. m.	Instructional courses.
1:00 to 5:00 p. m.	Instructional courses.
7:00 p. m.	Stag buffet dinner. Woman's Auxiliary dinner. Annual reception and dinner for women physicians. Joint entertainment.
Tuesday, October 20, 1953	
	Breakfast meetings of various groups.
10:00 to 11:40 a. m.	General scientific meeting.
Noon.	Luncheon meetings of committees, classes and fraternities.
2:00 to 4:30 p. m.	General scientific meeting.
Evening.	President's night. Address: PAUL D. CRIMM, M.D., Evansville, president. Entertainment.
Wednesday, October 21, 1953	
	Breakfast meetings of various groups.
7:30 a. m.	Final meeting of House of Delegates. (Breakfast meeting.)
	Council meeting.
11:00 a. m.	General scientific meeting.
Noon.	Group luncheons.
Afternoon.	Section meetings.
4:30 p. m.	Reception for members of 50-Year Club.
6:30 p. m.	Annual dinner-dance.

On motion of Drs. Geider and Hayes the Council approved the program as read.

5. *Scientific exhibit.* On motion of Drs. Olson and Catlett, the Council voted to have a scientific exhibit in 1953.

Membership Problems

1. 1952 Membership Report by districts:

MEMBERSHIP REPORT
Indiana State Medical Association
December 31, 1952

County Society	No. M.D.'s in County	Members Dec. 31, 1952	Members Dec. 31, 1951	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
1st District									
Posey	12	11	11	--	--	--	1	--	--
Vanderburgh	213	192	185	7	6	5	19	9	3
Warrick	14	8	9	-1	2	--	5	--	--
Spencer	9	6	7	-1	1	--	2	--	--
Perry	10	10	9	1	--	1	--	--	--
Gibson	26	25	25	--	1	1	1	1	--
Pike	9	8	6	2	--	1	1	--	1
Total	284	260	252	8	10	8	29	10	4
2nd District									
*Knox	47	46	42	4	--	3	2	--	--
Daviess-									
Martin	29	26	26	--	2	--	2	1	--
Sullivan	18	16	17	-1	2	--	--	1	--
*Greene	22	22	21	1	--	--	--	--	--
Owen-Monroe	57	55	49	6	1	5	--	2	--
Total	173	165	155	10	5	8	4	4	--
3rd District									
Lawrence	29	24	25	-1	1	--	4	1	--
Orange	13	13	9	4	--	--	1	--	--
*Harrison-									
Crawford	13	13	13	--	--	--	1	1	--
Washington	6	6	8	-2	--	--	1	--	--
Scott	6	4	4	--	--	--	2	--	--
*Clark	30	24	21	3	5	1	3	--	--
Floyd	34	31	34	-3	2	--	1	--	--
Dubois	24	16	14	2	5	3	--	3	--
Total	155	131	128	3	13	4	13	5	--
4th District									
Bartholomew-									
Brown	34	29	25	4	2	2	2	--	2
Jackson	22	18	18	--	2	--	2	1	--
Decatur	16	12	14	-2	2	--	2	--	--
*Jennings	10	8	9	-1	1	1	1	1	--
Ripley	15	12	10	2	3	--	--	--	--
Jefferson-									
Switzerland	31	27	25	2	3	2	4	3	--
*Dearborn-Ohio	17	15	16	-1	--	--	--	1	1
Total	145	121	117	4	13	5	11	6	3
5th District									
Parke-									
Vermillion	30	24	25	-1	4	--	2	2	--
Putnam	20	19	19	--	--	--	--	1	--
Vigo	125	112	116	-4	4	2	7	3	4
Clay	15	12	11	1	1	1	2	1	--
Total	190	167	171	-4	9	3	11	7	4
6th District									
Hancock	21	18	16	2	1	1	--	3	--
*Henry	43	41	39	2	2	3	1	1	--
*Wayne-Union	82	69	71	-2	4	2	9	--	3
Rush	16	13	13	--	1	--	2	1	--
Fayette-									
Franklin	24	22	25	-3	1	--	2	4	--
Shelby	27	22	23	-1	--	1	4	1	--
Total	213	185	187	-2	9	7	18	10	3

County Society	No. M.D.'s in County	Members Dec. 31, 1952	Members Dec. 31, 1951	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
7th District									
Hendricks	20	17	20	-3	--	--	1	--	2
*Marion	1008	896	874	22	16	57	77	16	15
Morgan	20	16	14	2	3	--	2	1	--
Johnson	24	21	19	2	1	2	2	--	1
Total	1072	950	927	23	20	59	82	17	18
8th District									
Madison	103	95	92	3	5	2	4	--	2
*Delaware-									
Blackford	119	100	96	4	12	4	5	1	3
Jay	21	16	16	--	3	1	1	2	1
Randolph	25	21	23	-2	3	--	--	1	--
Total	268	232	227	5	23	7	10	4	5
9th District									
*Benton	11	10	8	2	--	1	--	1	--
*Fountain-									
Warren	17	17	19	-2	--	1	2	--	--
*Tippecanoe	108	98	95	3	7	3	4	1	--
*Montgomery	31	26	29	-3	2	--	3	--	--
Clinton	31	24	24	--	5	--	4	1	--
Tipton	15	11	13	-2	1	--	3	--	--
Boone	25	20	20	--	3	--	3	--	--
*Hamilton	27	23	22	1	1	1	2	1	1
White	7	4	3	1	1	1	--	--	2
Total	272	233	233	--	20	7	21	4	3
10th District									
Lake	341	320	314	6	6	10	21	6	2
*Porter	26	24	24	--	2	--	2	--	--
Jasper-									
Newton	20	17	18	-1	--	2	4	2	--
Total	387	361	356	5	8	12	27	8	2
11th District									
Carroll	10	10	10	--	--	1	--	1	--
Cass	51	36	36	--	7	1	4	3	2
Miami	25	19	19	--	2	--	--	3	1
Wabash	29	23	24	-1	3	--	4	1	--
Huntington	26	23	24	-1	2	--	--	2	1
Howard	49	44	42	2	--	3	5	1	2
*Grant	60	49	49	--	9	4	3	--	--
Total	250	204	204	--	23	9	16	11	6
12th District									
LaGrange	9	8	8	--	1	--	--	--	--
Steuben	15	12	13	-1	1	--	3	--	--
*Noble	26	23	25	-2	3	--	4	1	--
DeKalb	24	20	20	--	3	--	2	--	--
Whitley	14	11	11	--	2	1	--	2	--
Allen	225	210	202	8	7	10	11	2	5
Wells	32	28	29	-1	1	1	2	1	--
Adams	19	19	18	1	--	--	2	1	--
Total	364	331	326	5	18	12	24	7	5
13th District									
LaPorte	89	78	73	5	7	7	6	1	--
St. Joseph	234	206	203	3	17	5	10	4	6
*Elkhart	96	89	89	--	2	1	8	2	--
*Starke	9	7	7	--	1	--	--	1	--
Pulaski	8	8	7	1	--	1	--	1	--
Fulton	12	12	12	--	--	1	--	--	--
Marshall	24	17	16	1	4	--	2	1	1
Kosciusko	20	14	12	2	4	2	4	1	--
Total	492	431	419	12	35	17	30	11	7

SUMMARY BY DISTRICT

1st District	284	260	252	8	10	8	29	10	4
2nd District	173	165	155	10	5	8	4	4	--
3rd District	155	131	128	3	13	4	13	5	--
4th District	145	121	117	4	13	5	11	6	3
5th District	190	167	171	-4	9	3	11	7	4
6th District	213	185	187	-2	9	7	18	10	3
7th District	1072	950	927	23	20	59	82	17	18
8th District	268	232	227	5	23	7	10	4	5
9th District	272	233	233	--	20	7	21	4	3
10th District	387	361	356	5	8	12	27	8	2
11th District	250	204	204	--	23	9	16	11	6
12th District	364	331	326	5	18	12	24	7	5
13th District	492	431	419	12	35	17	30	11	7
Total	4265	3771	3702	69	206	158	296	104	60

* Physicians are listed in the counties in which they hold membership; not in the counties in which they reside.

78 physicians received membership gratis in 1952 because of military service.

252 physicians were senior members in 1952.

1 physician was an honorary member.

145 physicians paid dues of \$10.00 in 1952 as residents and interns.

62 physicians had their dues remitted by the Council in 1952.

2. *Delegates to the A.M.A.* The secretary announced that a letter had been received from Dr. George F. Lull, secretary of the American Medical Association, stating that Indiana would be entitled to four A.M.A. delegates for the year 1953.

3. *Remission of state dues.* On motion of Drs. Olson and Geider, the Council voted to remit the 1953 dues of nine members who had been certified by their respective county medical society secretaries.

On motion of Drs. Doty and Catlett, the dues of a Lake County member, who had been certified by the Lake County secretary, are to be remitted as long as this member is not in active practice.

Legislative Matters

1. Drs. Ochsner and Wright, co-chairmen of the Legislative Committee, spoke briefly of the activities of the General Assembly to date and asked the Council to take action on several pending matters of interest to the medical profession.

2. *Digression from Intent of House of Delegates Resolutions.* Dr. Blazey presented the following:

At the last session of the House of Delegates of the I.S.M.A. a resolution was passed to inform individual members about the full implication of Section 3, of P.L. 590. The "appropriate action" mentioned in that resolution was never implemented by specifying methods of informing our membership. As a result, there has been no information disseminated by the I.S.M.A. in the past three months pursuant to the intent of the resolution. On the contrary, there has appeared in our Journal the following statements: "This does not mean the end of the issue (compulsory health insurance), but a safe assumption is that it will lie dormant for the next two years." (pink section 12/52); and, "General Eisenhower's firm stand against National Compulsory Health Insurance, should put an end, at least during the coming four years, to any serious consideration of this socialistic scheme in The Congress." (page 1260, 12/52)

Meanwhile, the 83rd. Congress has gone into session, and 10% of the bills thus far presented are on health

and welfare subjects. Dingell's H.B. 8 has reintroduced Ewing's plan to give socialized medicine to persons 65 years or older as hospital care. H.B. 9, by Dingell, would put into permanent effect next July 1st. the provisions of Section 3, P.L. 590. Rogers of Massachusetts has introduced no less than four bills to increase the scope of non-service-connected disabilities to be treated at public expense in Veteran's Hospitals, one to increase the scope of veteran's care abroad, and one to increase, by 16,000, the number of beds in Veteran's Hospitals. Rivers of S.C. requests hospital and medical care for military dependents. (AMA Washington Letter 1/9/53) All of these measures are an increase of already excessive procedures that have been foisted upon an unsuspecting electorate in previous years for the purpose of establishing, bit-by-bit, socialized medicine.

In further consideration of action taken at our last House of Delegates, attention is directed to the fact that our Veteran's Affairs committee was to meet with representatives of the American Legion and other interested groups for the purpose of discussing the objectionable features of P.L. 312 that created by 1951 a bed occupancy for non-service-connected disability of 66%. More specifically, some thought that the purpose of that liaison committee was to point out the socialized medicine features of that 66% figure in basic terms for discussion with the other groups in order that they might be more familiar with the reasons why the I.S.M.A. membership did not want that evil to continue. In the words of Dr. Phillip Reed, "—it (ISMA) does wish to correct certain practices that are derogatory to our system of government and the standards of medical care."

In the minutes of the first liaison committee meeting of November 23, 1952, there is no mention of the participants discussing the basic philosophy of providing federal medical care to veterans with non-service-connected disabilities. On the other hand the individuals at that meeting unanimously adopted a "no tinkering" policy in respect to the provisions of P.L. 312 as it has stood for the last seventeen years, to create during those years a gradual but steady increase in the care of cases that should be handled at a local level. One minor constructive element was agreed upon—that was the future working out of means to exclude the small group of "chiselers" who really could pay for their care elsewhere.

It is self evident that there are not sufficient local facilities available to care for the 40 or more percent of T.B. and N.P. cases that are not service-connected but who now occupy beds in Veteran Hospitals. The necessity to continue their care in V.A. Hospitals until local facilities are available is axiomatic. Yet, to make these concessions without any mention of the error of their inclusion in P.L. 312 is to sanction a form of socialized medicine by holding one's tongue when one should speak out. Let the words of Louis Bauer be incorporated in the minutes and conclusions of future meetings: "That, because of the lack of adequate community facilities, all non-service-connected cases of tuberculosis and neuropsychiatric disorders should be treated in veteran's facilities, until such time as local community facilities might become available."

These matters have been called to your attention in the hope that this Council will see fit to advise the members of our Veterans Affairs Committee that we feel it is necessary to bring out and discuss the moral issues at stake in the thus far unopposed federal medical care of any indigent non-service-connected disability, and that this Council will also instigate appropriate action to implement the intended purpose of the grass-roots action resolution on Section 3 of P.L. 590.

Dr. Palm stated that the Liaison Committee had met twice and he felt the Veterans Committee would have something concrete on this subject to

present, probably at the interim meeting of the House of Delegates in April.

3. *A.M.A. delegates' report.* Dr. Nafe reviewed briefly the proceedings and actions of the A.M.A. House of Delegates at the Denver meeting, December 2 to 4, 1952. (For complete report, see pages 129-134, February Journal, 1953.)

In Memoriam

The Council stood for a minute in tribute to Dr. Cyrus J. Clark, who served for 12 years as councilor from the Seventh District, and who at the time of his death, on January 22, 1953, was chairman of the Executive Committee.

The Council directed the secretary to write a memorial resolution on Dr. Clark, to be spread upon the minutes of this Council meeting, and a copy to be sent to his family.

Executive Session

The Council went into executive session, and met again in regular session following lunch.

New Business

1. *Matters referred to Council by Executive Committee.*

(a) On motion of Drs. Blazey and Catlett, the secretary was given authority to make whatever changes are necessary to simplify the keeping of the association's financial records, and to improve the method used in keeping the records of the headquarters office.

(b) *Resolution on Public Law 779 adopted by the Council of the Indianapolis Medical Society.* Dr. Porteus read the following resolution, which, on motion of Drs. Blazey and Geider, was adopted by the Council:

"WHEREAS some questions have arisen regarding the constitutionality of Public Law 779, generally known as the 'Doctors' Draft Act,' and

"WHEREAS, the Council on Emergency Medical Service of the American Medical Association now is conferring with Defense Department officials, Selective Service officials and representatives of the U. S. Public Health Service regarding possible revisions of the law which expires June 30, 1953; and

"WHEREAS, these conferences present an excellent opportunity for study and review of the actual constitutionality of the law on two points: (1) Is legislation of this type, which imposes on one professional group a double liability for military service, class legislation and, as such, violates constitutional guarantees?; and (2) Is the Army in drafting doctors and using them as enlisted men violating the due process provision of the constitution?; and

"WHEREAS, while it is fully realized that Public Law 779 was established with a view toward fairly obtaining physicians for the Armed Services after other methods of procurement had failed, it also must be realized that no legislation should be allowed to remain on the statute books which actually is unconstitutional inasmuch as it may be an entering wedge for future constitutional violations;

"WHEREAS, upon the enactment of the law which would replace Public Law 779, should there exist any doubt as to its constitutionality, a case in point should be tested before a United States Court to determine whether or not it violates the constitutional rights of the individual;

"THEREFORE, BE IT RESOLVED that officials of the American Medical Association in their conferences with interested governmental officials make every possible effort looking toward the law's revision in such manner as to insure its constitutionality and,

"BE IT FURTHER RESOLVED that a copy of this resolution be handed to the Executive Committee and Council of the Indiana State Medical Association and that they in turn be requested to forward it to proper officials of the American Medical Association and,

"BE IT FURTHER RESOLVED that the Indiana State Medical Association send a copy of this resolution to all members of the state's congressional delegation."

Later in the meeting, following discussion by Drs. Geider and Olson, the Council passed their motion to reconsider the above action in which the Council approved this resolution.

On motion of Drs. Topping and Olson, the original motion was tabled until the next meeting of the Council, at which time the matter can be passed on to the House of Delegates.

2. *Nominations for Editorial Board.* Dr. Catlett nominated Dr. Samuel Mercer of Fort Wayne (dermatology).

3. *Interim meeting of House of Delegates* is to be held April 26, 1953, in Indianapolis, at a place to be selected by the secretary.

4. *Spring meeting of the Council* to be held at 6:30 p. m., Saturday, April 25, in Indianapolis.

5. *Dates for 1954 annual convention.* On motion of Drs. Geider and Combs, tentative dates of September 28, 29 and 30, 1954, were set for the 1954 convention, to be held at Fort Wayne. Dr. Howard suggested that the secretary report at the next meeting of the Council on the accommodations available in Fort Wayne for a state convention.

Elections for 1953

1. *Chairman of the Council.* On ballot vote, Dr. Elton R. Clarke of Kokomo was elected chairman of the Council for 1953.

2. *Executive Committee members.* Dr. W. L. Portteus of Franklin and Dr. James W. Denny of Indianapolis were elected members of the Executive Committee for 1953.

3. *Assistant treasurer.* Dr. Maurice V. Kahler of Indianapolis was elected assistant treasurer, to succeed Dr. James W. Denny.

A rising vote of thanks was given Dr. Dodds for his diligent work and service as chairman of the Council for the past year.

There being no further business, the meeting was adjourned.

COMMITTEE ON PUBLICITY

December 17, 1952

Meeting called to order at 4:30 p.m.

Present: E. H. Clauser, M.D., Chairman; D. S. Megenhardt, M.D.; Norbert M. Welch, M.D.; and Homer G. Hamer, M.D.

Minutes of the meeting held November 14, 1952 were read and approved.

The following "Hints on Health" columns were read and approved:

Week of December 29, 1952—"The Common Cold"

Week of January 5, 1953—"Bed Wetting"

Week of January 12, 1953—"Children?"

Week of January 19, 1953—"Glaucoma"

Week of January 26, 1953—"Overweight"

Week of February 2, 1953—"Germ Warfare"

Week of February 9, 1953—"Diabetic Gangrene"

Week of February 16, 1953—"Animal Diseases"

A release on Polio for the Indiana Farmers Guide was read and approved.

A letter from Hazel Cassaday was read and a reply formulated.

There being no further business, the meeting was adjourned to meet again at 4:30 p.m., on Wednesday, January 14, 1953, in the headquarters office.

These minutes were approved in each separate part and as a whole on January 14, 1953.

LOCAL SOCIETY REPORTS

Carroll County Medical Society members and their wives were entertained at a dinner meeting January 21 in the home of Dr. George W. Wagoner, Delphi. A paper on "Subluxations of Cervical Spine" was given by Dr. W. G. Hunsberger, radiologist at St. Elizabeth Hospital, Lafayette, following the dinner.

Members of **Floyd County Medical Society** held a meeting in the New Albany Country Club on January 9 at which time they heard a discussion concerning the operation of the new Floyd County Memorial Hospital. W. L. Mauzey, hospital administrator, was the speaker. Election of hospital staff officers resulted in naming Dr. W. F. Edwards, president; Dr. Percy R. Pierson, vice-president, and Dr. Gene S. Pierce, secretary-treasurer. Dr. John M. Paris and Dr. Wm. H. Garner were named to a joint advisory committee.

Nine members of **Adams County Medical Society** met January 13 in Adams County

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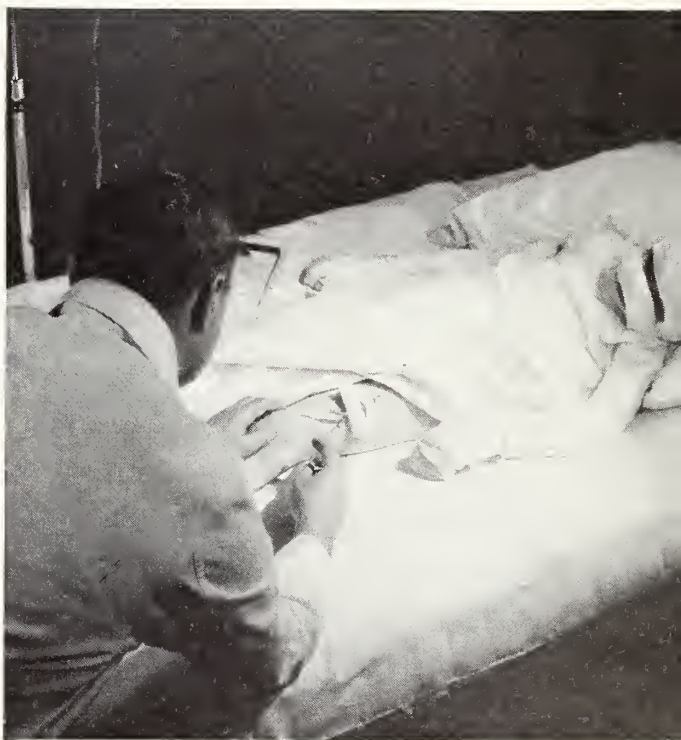
In burns—Plasma and electrolyte solutions can be given subcutaneously at effective rates when Alidase is employed; collapsed veins or risks of thrombosis are not a problem with this method.



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Hechter, Dopkeen and Yudell¹ have found that the use of hyaluronidase has "markedly increased the rates of absorption and administration of hypodermoclysis with no untoward reactions." They also found that extremely small amounts of this enzyme facilitated the absorption of fluids in that greater amounts of fluids were absorbed by the patient in a given period of time and that the localized swelling following hypodermoclysis disappeared more promptly.

Similar results with Alidase were recounted by Schwartzman, Henderson and King.² They observed "that absorption of various types of solutions, such as saline, glucose in saline, Hartmann's solution, Ringer's solution, penicillin, streptomycin, Adrenalin, and procaine was facilitated in every case."



In toxemias of pregnancy—Urgently-needed parenteral fluids may be administered subcutaneously with the aid of Alidase, eliminating risk of thrombosis attending repeated intravenous administration of electrolyte solutions. Alidase is the highly purified Searle brand of hyaluronidase and is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

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1. Hechter, O.; Dopkeen, S. K., and Yudell, M. H.: The Clinical Use of Hyaluronidase in Hypodermoclysis, *J. Pediat.* 30:645 (June) 1947.
2. Schwartzman, J.; Henderson, A. T., and King, W. E.: Hyaluronidase in Fluid Administration: A Preliminary Report, *J. Pediat.* 33:267 (Sept.) 1948.

Memorial Hospital, Decatur, for a brief business meeting at 5 p.m. The February meeting was scheduled for the same hour and place, on February 10.

The entire membership of **Green County Medical Society**, 20 doctors, met January 15 in Freeman Greene County Hospital, Linton, to hear a paper on "Infant Diarrheas" which was presented by Dr. George V. Teter, Indianapolis.

Clay County Medical Society held a regular dinner meeting in the Brazil Elks' Club on January 20 with Robert J. Amick, field representative of Indiana State Medical Association, as the speaker. Eight members and two associate members attended.

Steuben County Medical Society met at 5:30 p.m. on January 20 in Cameron Hospital, Angola. Following dinner an ISMA wire recorded telephone seminar on "Hypertension" was presented and election of officers for 1954 concluded the program. Nine members attended.

A joint meeting of **Johnson County Medical Society**, the board of trustees and superintendent of Johnson County Memorial Hospital was held January 14 at 6:30 p.m. in the Franklin College Student Center, Franklin. The 17 persons present held a roundtable discussion of many of the problems that arise in the operation of a county hospital.

Twenty-five members of **Laporte County Medical Society** met for dinner in Peacock Fountain Inn, Rolling Prairie, on January 15 and heard a paper by Dr. Danely P. Slaughter, University of Illinois College of Medicine, who spoke on "Recent Advances in the Treatment of Cancer."

A new emergency medical service plan for the community was set up at the January 14 meeting of **Bartholomew-Brown County Medical Society** in the Bartholomew County Hospital, Columbus. The 25 members present also heard announcement of the committees which will function during 1953.

"Practical Aspects of Neuropsychiatry" were discussed by Dr. Dwight Schuster, Indianapolis, before 19 members of the **Shelby County Medical Society** in the W.S. Major Hospital, Shelbyville, on January 14. Announcement of committee appointments was made, a report from the headquarters office was given by the field secretary and it was announced that the February meeting was to be held jointly with the Indiana Academy of General Practice.

The speaker scheduled for the January 8 meeting of the **Wayne-Union County Medical Society** was unable to attend. No substitution was made, however 30 members enjoyed dinner in the Leland Hotel, Richmond, and held a short business meeting.

Montgomery County Medical Society members met in Culver Hospital, Crawfordsville, January 15, when they heard addresses by two Indianapolis specialists, Dr. John H. Greist, assistant professor of psychology at Indiana University School of Medicine, and Dr. Charles W. Cure, neuro-surgeon. Both speakers discussed diagnosis and treatment of diseases of the brain. Dr. Wemple Dodds, president, presided.

Election of officers and plans for the Ninth Medical District meeting in Noblesville on May 27 were principal items of business transacted at the January 13 meeting of the **Hamilton County Medical Society** in Riverview Hospital cafeteria, Noblesville.

Dr. Haldon C. Kraft, Noblesville, was named president of the society; Dr. John Hash, vice-president, and Dr. Sam Campbell, secretary-treasurer. A discussion on "Medical Emergencies" and a tape recording of a medical seminar completed the program.

Seventeen members of the **Shelby County Medical Society** met with the new president, Dr. Roger Whitcomb, in the William S. Major Hospital January 14. Dr. Dwight Schuster, Indianapolis, spoke on "The Practical Aspects of Neuro-Psychiatry". New committees were appointed during a business session.



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Cass County Medical Society members and their wives met for a 6:30 p.m. dinner meeting in Memorial Hospital, Logansport, January 19, after which they listened to a recorded telephone seminar on "Hypertension". Dr. K. G. Kohlstedt moderated the program; Drs. Richard S. Griffith and Morris E. Thomas discussed medical management; Dr. Harris Schumacker, Jr., surgical management, and Dr. O. M. Helmer, diagnosis.

Sgt. Elmer Paul of the Indiana State Police Crash Injury Research Division and Lt. R. F. Borkenstein, laboratory expert, discussed some of the work being done to solve the Indiana highway death problem and outlined several new approaches to solution of the problem at a meeting of the **Howard County Medical Society** held on January 6 in the Francis Hotel, Kokomo. Thirty-three doctors saw visual aids used by the State Police, including charts of automobile design in relation to accidents, photographic blow-ups of actual wreckage, heard a discussion of the drunken and the drinking driver together with some facts concerning the drunkometer. Injury report forms were distributed to the doctors and the need for close cooperation between the police and physician stressed.

The newly elected Howard county coroner, John Peacock, was a special guest completing the three-way public relations link. New officers began their terms with this meeting.

A business meeting for the purpose of collecting dues was held following a dinner in the Vermillion County Hospital at Clinton on January 21. Twelve members of **Parke-Vermillion County Medical Society** attended.

Dr. Bernard Rosenak, Indianapolis, and Dr. Fred Fitz, Chicago, were guest speakers at the January 13 meeting of **Tippecanoe County Medical Society** in Lincoln Lodge. Doctor Rosenak's topic was "Liver" and Doctor Fitz spoke on "Hypertension". Forty-eight members and 10 guests, including Dr. Russell Spivey, president of the Indiana Academy of General Practice, and Dr. Norman Booher, secretary of the Academy, attended.

Dr. William L. Marsh was admitted to membership in the society and it was voted to have the treasurer set up new books which could be audited more readily. Several other matters pertaining to society business were discussed and it was announced that lists of 1953 committee appointments will be mailed all members; resolutions to be presented to the House of Delegates in April should be sent to the headquarters office 30 days before the meeting of the House and all members were urged to attend the February meeting which was to be addressed by Leo Brown, publicity director for AMA.

Unions Aid Heart Campaign

Additional support for the Indiana Heart Foundation's research program has been pledged by Neal Edwards, president of the Indiana Council of Industrial Organizations, and by Carl Mullen, president, Indiana Federation of Labor. Contributions made by union organizations to the Indiana Heart Foundation will be kept separate and credited as statewide memorials to the late Philip Murray and William Green, who died recently of heart attacks. Each of the union presidents was an active supporter of the heart program.

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MONTHLY REPORT—DECEMBER 1952

Disease	Dec. 1952	Nov. 1952	Oct. 1952	Dec. 1951	Dec. 1950
Chickenpox	413	516	117	389	341
Conjunctivitis	1	1	0	2	0
Diarrhea	3	4	6	0	0
Diphtheria	6	2	1	5	7
Dysentery, Unclassified	2	2	0	0	0
Encephalitis	2	2	2	1	3
Influenza	52	145	69	46	10
Infectious hepatitis	48	40	16	22	3
Measles	33	41	6	440	191
Meningitis,					
Unclassified	4	6	1	7	8
Meningococcal	5	4	2	1	1
Mumps	93	93	39	288	82
Paratyphoid	2	1	1	0	2
Pneumonia	44	48	39	44	74
Poliomyelitis	23	120	407	11	35
Rabies, animal	1	7	5	27	33
Rheumatic fever	2	0	1	3	1
Rubella	17	10	4	20	13
Streptococcal infections	213	173	69	182	146
Tinea capitis	2	1	4	0	22
Tularemia	2	5	0	3	7
Vincent's angina	5	5	4	0	0
Whooping cough	32	30	30	108	212
Hookworm	1	0	1	0	0

INDIANA STATE BOARD OF HEALTH

Division of Communicable Disease Control

Disease	Nov. 1952	Oct. 1952	Sept. 1952	Nov. 1951	Nov. 1950
Brucellosis	1	2	0	2	5
Chickenpox	516	117	13	146	177
Conjunctivitis,					
(pink eye)	1	0	2	0	6
Diarrhea	4	6	8	0	0
Diphtheria	2	1	0	17	4
Dysentery, amoebic	1	0	0	0	2
Shigella	139	3	0	0	0
Encephalitis	2	2	5	1	3
Food infection	2	0	0	0	26
Impetigo	3	5	3	1	0
Influenza	145	69	39	74	21
Infectious hepatitis	40	16	16	16	3
Malaria	1	0	1	1	0
Measles	41	6	17	95	37
Meningitis,					
Unclassified	6	1	4	8	3
Meningococcal	4	2	0	1	2
Mumps	93	39	19	132	90
Paratyphoid	1	1	0	2	1
Pneumonia	48	39	21	29	62
Poliomyelitis	120	407	482	32	105
Rabies, animal	7	5	12	20	43
Rat Bite fever	1	0	0	0	0
Rubella	10	4	0	13	2
Streptococcal Inf.	173	69	17	104	62
Tinea capitis	1	4	0	0	21
Tularemia	5	0	0	0	4
Typhoid	3	3	4	2	2
Vincent's angina	5	4	1	0	2
Whooping cough	30	30	43	99	151

Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

HANDBOOK OF ORTHOPAEDIC SURGERY. By Alfred Rives Shands, M.D., medical director of Alfred I. duPont Institute of Nemours Foundation, Wilmington, Del.; visiting professor of orthopaedic surgery, University of Pennsylvania School of Medicine; in collaboration with Richard B. Raney, M.D., professor of orthopaedic surgery, University of North Carolina and lecturer in Orthopaedics, Duke University. Fourth edition. 644 pages, generously illustrated. Price \$8.00. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Mo. 1952.

2nd ANNUAL REPORT ON STRESS. By Hans Selye, M.D., director and professor University of Montreal and Alexander Horava, M.D., research associate and librarian, Institute of Medicine, University of Montreal. 526 pages. Price \$10.00 (plus 34c postage). Acta, Inc., Medical Publishers, 5465 Decarie Blvd., Montreal, Canada. 1952.

PRACTICE OF PSYCHIATRY. By William S. Sadler, M.D., Chicago, consulting psychiatrist to Columbus Hospital and Pinel Sanitarium, 1183 pages. Price \$15.00. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Mo. 1953.

CLINICAL ALLERGY. By French K. Hansel, M.D., director, Hansel Foundation for Education and Research in Allergy, chief of allergy service, DePaul Hospital, St. Louis, 1005 pages with 80 illustrations, 3 color plates. Price \$17.50. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Mo. 1953.

ENDOCRINE TREATMENT IN GENERAL PRACTICE. Written by 21 clinicians in many fields of medicine and edited by Max A. Goldzieher, M.D. and Joseph W. Goldzieher, M.D., 474 pages, illustrated. Price \$8.00. Springer Publishing Company, Inc., 44 East 23rd Street, New York 10, N. Y. 1953.

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Flash

From Washington, D. C.

Delegates to the American Medical Association were told a complete investigation and re-evaluation of the responsibility and part the government is taking in providing health services to the people is to be made.

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Opinions From Here and There

Prepared for your information by the Committee on Public Policy and
Legislation of the Indiana State Medical Association

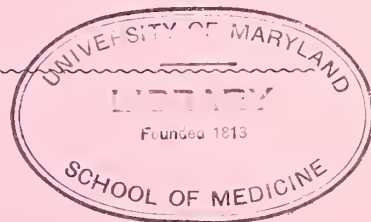
REORGANIZATION PLAN No. 1 OF 1953—Prepared by the President and transmitted to the Senate and the House of Representatives in Congress assembled, March 12, 1953, pursuant to the provisions of the Reorganization Act of 1949, approved June 20, 1949, as amended

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE — Section 1.

Creation of Department: Secretary.—There is hereby established an executive department, which shall be known as the Department of Health, Education, and Welfare (hereafter in this reorganization plan referred to as the Department). There shall be at the head of the Department a Secretary of Health, Education, and Welfare (hereafter in this reorganization plan referred to as the Secretary), who shall be appointed by the President by and with the advice and consent of the Senate, and who shall receive compensation at the rate now or hereafter prescribed by law for the heads of executive departments. The Department shall be administered under the supervision and direction of the Secretary.

Sec. 2. Under Secretary and Assistant Secretaries.—There shall be in the Department an Under Secretary of Health, Education, and Welfare and two Assistant Secretaries of Health, Education, and Welfare, each of whom shall be appointed by the President by and with the advice and consent of the Senate, shall perform such functions as the Secretary may prescribe, and shall receive compensation at the rate now or hereafter provided by law for under secretaries and assistant secretaries, respectively, of executive departments. The Under Secretary (or, during the absence or disability of the Under Secretary or in the event of a vacancy in the office of Under Secretary, an Assistant Secretary determined according to such orders as the Secretary shall prescribe) shall act as Secretary during the absence or disability of the Secretary or in the event of a vacancy in the office of Secretary.

Sec. 3. Special Assistant.—There shall be in the Department a Special Assistant to the Secretary (Health and Medical Affairs) who shall be



appointed by the President by and with the advice and consent of the Senate from among persons who are recognized leaders in the medical field with wide non-governmental experience, shall review the health and medical programs of the Department and advise the Secretary with respect to the improvement of such programs and with respect to necessary legislation in the health and medical fields, and shall receive compensation at the rate now or hereafter provided by law for assistant secretaries of executive departments.

Sec. 4. Commissioner of Social Security.—There shall be in the Department a Commissioner of Social Security who shall be appointed by the President by and with the advice and consent of the Senate, shall perform such functions concerning social security and public welfare as the Secretary may prescribe, and shall receive compensation at the rate now or hereafter fixed by law for Grade GS-18 of the general schedule established by the Classification Act of 1949, as amended.

Sec. 5. Transfers to the Department.—All functions of the Federal Security Administrator are hereby transferred to the Secretary. All agencies of the Federal Security Agency, together with their respective functions, personnel, property, records, and unexpended balances of appropriations, allocations, and other funds (available or to be made available), and all other functions, personnel, property, records, and unexpended balances of appropriations, allocations, and other funds (available or to be made available) of the Federal Security Agency are hereby transferred to the Department.

Sec. 6. Performance of Functions of the Secretary.—The Secretary may from time to time make such provisions as the Secretary deems appropriate authorizing the performance of any of the functions of the Secretary by any other officer, or by any agency or employee, of the Department.

Sec. 7. Administrative Services.—In the interest of economy and efficiency the Secretary may from time to time establish central administrative services in the fields of procurement, budgeting, accounting, personnel, library, legal, and other services and activities common to the several agencies of the Department; and the Secretary may effect such transfers within the Department of the personnel employed, the property and records used or held, and the funds available for use in connection

with such administrative service activities as the Secretary may deem necessary for the conduct of any services so established: *Provided*, That no professional or substantive function vested by law in any officer shall be removed from the jurisdiction of such officer under this section.

Sec. 8. Abolitions.—The Federal Security Agency (exclusive of the agencies thereof transferred by section 5 of this reorganization plan), the offices of Federal Security Administrator and Assistant Federal Security Administrator created by Reorganization Plan No. 1 (53 Stat. 1423), the two offices of assistant heads of the Federal Security Agency created by Reorganization Plan No. 2 of 1946 (60 Stat. 1095), and the office of Commissioner for Social Security created by section 701 of the Social Security Act, as amended (64 Stat. 558), are hereby abolished. The Secretary shall make such provisions as may be necessary in order to wind up any outstanding affairs of the Agency and offices abolished by this section which are not otherwise provided for in this reorganization plan.

Sec. 9. Interim Provisions.—The President may authorize the persons who immediately prior to the time this reorganization plan takes effect occupy the offices of Federal Security Administrator, Assistant Federal Security Administrator, assistant heads of the Federal Security Agency, and Commissioner for Social Security to act as Secretary, Under Secretary, and Assistant Secretaries of Health, Education, and Welfare and as Commissioner of Social Security, respectively, until those offices are filled by appointment in the manner provided by sections 1, 2, and 4 of this reorganization plan, but not for a period of more than 60 days. While so acting, such persons shall receive compensation at the rates provided by this reorganization plan for the offices the functions of which they perform.

**REPORT OF BOARD OF TRUSTEES ON REORGANIZATION PLAN No. 1
OF 1953 AS ADOPTED BY THE HOUSE OF DELEGATES**—Presented by
Dwight H. Murray, M.D., Chairman, to House of Delegates, March 14, 1953

The House of Delegates of the American Medical Association has for nearly 80 years been on record as favoring an independent Department of Health in the federal government. The reason for this stand has been that the House has felt that health and medicine should be given a status commensurate with their dignity and importance in the lives of the American people, and that they should be completely divorced from any political considerations.

The Board of Trustees, after a careful study of the policy of the American Medical Association with respect to the administration of health activities in the Executive Branch of the government and after studying the Reorganization Plan for elevation of the Federal Security Agency to cabinet status submitted by President Eisenhower to the Congress, finds that Reorganization Plan No. 1 of 1953 provides for a special assistant to the Secretary of Health and Medical Affairs. This provision is a step in the right direction which should result in centralized coordination under a leader in the medical field of the health activities of the proposed department. Health, therefore, is given a special position. The proposed plan, properly administered, will permit more effective coordination and administration of the health activities of the new Department without interference or control by other branches.

Previous attempts to raise the Federal Security Agency from an independent agency to the level of an Executive Department have been opposed by the Association because the plan did not meet these aims.

Inasmuch as federal health benefits and programs are established by the Congress, an administration bent on achieving the nationalization of medicine cannot reach that goal except with the support of Congress. Therefore, an organizational plan through which federal health activities are administered, although important, is not nearly so vital an issue as the policies adopted by the Congress of the United States.

The Board of Trustees recommends that the House of Delegates reaffirm its stand in favor of an independent Department of Health but that it support the Reorganization Plan No. 1 of 1953 as being a step in the right direction; that the American Medical Association cooperate in making the plan successful and that it watch its development with great care and interest.

It should be understood, however, that the Association reserves the right to make recommendations for amendment of the then existing law and to press for the establishment of an independent Department of Health, if the present plan does not, after a sufficient length of time for development, result in proper advancement in and protection of health and medical science and in their freedom from political control.

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HORMONE-PRODUCING TUMORS OF THE OVARY

DAVID A. BICKEL, M. D. and

JENE R. BENNETT, M.D.*

South Bend

FUNCTIONING tumors of the ovary received slight recognition and no critical study prior to the investigations of the late Robert Meyer¹. These tumors had come under the observation of pathologists for many years, and were considered to be bizarre carcinomas and sarcomas.* The specific effects of their endocrine function are now generally recognized, and as a group of related neoplasms, they have aroused intense clinical and pathological interest. Cases of functioning ovarian tumors are being so rapidly reported that a voluminous literature is accumulating on the subject. It is generally accepted that these neoplasms have a common histogenesis; that is, they arise from undifferentiated embryonic cells within the ovary. Pathologically, they are placed in a group of comparatively rare neoplasms designated as special ovarian tumors. Although histogenically related, all of the group do not exhibit specific endocrine function. The function-

ing tumors which have been described in this group are the feminizing neoplasms, granulosa cell tumors and thecomas; and the masculinizing neoplasms, arrhenoblastomas and rare adrenal rest tumors. Also included in the group are two tumors which do not produce hormones or clinical effects. They are described in this group because they are also thought to arise from cells in the undifferentiated stage of gonadal development. One of the tumors is the dysgerminoma which histologically resembles the seminoma, a malignant testicular tumor. Although not exhibiting any specific sex function, dysgerminomas have been reported to be associated with deficient sex development and pseudohermaphroditism. The so-called Brenner tumor, which is non-functioning, is also included in this group; it arises from inclusions of undifferentiated cells in and around the ovary, known as Walthard rests.

The case studies and the pathology of five cases of functioning ovarian tumors are presented in this report.

*From the South Bend Medical Foundation, 531 N. Main Street, South Bend, Indiana.

Case I. Granulosa Cell Tumor

This patient was a 38-year-old nulliparous colored woman, a patient of Dr. J. A. Abel of South Bend, Indiana. Menometrorrhagia had been present intermittently for about two years, and a few months before admission to the hospital January 18, 1949, the patient observed a firm painless mass in the right side of the lower abdomen. She was well nourished, and the general physical examination was negative. Laboratory findings were: serology, negative; urine, negative; red blood cells, 4,900,000 cmm.; hemoglobin 11.9 gm. per cent.

At operation, a large solid tumor was found to arise from the right ovary. This mass was encapsulated and was not adherent to the surrounding structures. The other pelvic organs were grossly normal. The surgery in this case consisted of removal of the right tube and entire ovary with the tumor. The appendix was also removed. The pertinent pathological findings are as follows: The specimen consisted of an oval-shaped mass stated to represent a right ovarian tumor measuring 13 x 12 x 7.5 cm. and weighing 545 gm. A capsule completely enclosed the mass, and an elongated Fallopian tube was attached to its surface. The tube measured approximately 11 cm. in length and appeared grossly normal. On section, the mass was seen to be a solid tumor mainly composed of yellowish white, slightly granular lobulated tumor tissue in which there were areas of hemorrhagic necrosis. Microscopic examination of the sections (Fig. 1) of the ovarian tumor tissue showed the cells composing the neoplasm to be uniform in morphology but to show moder-

ate numbers of mitotic figures. The cells in some areas showed an arrangement about a central lumen resembling Call-Exner bodies. In other areas of the tumor, there were microscopic cysts, and also in other areas, there was a cylindromatous pattern of histologic structure. *Pathological Diagnosis:* Granulosa cell tumor.

This patient has been followed since the tumor was removed; her general health has been good, and menstruation has been regular and normal, but she had not become pregnant.

Comment (Granulosa Cell Tumor)

The granulosa cell tumor is the most common functioning ovarian tumor; almost a thousand cases have been reported in the literature². Although development of this tumor has been observed at various ages, the majority of reported cases have been in women who have passed the menopause³. The cells which make up this tumor are epithelial in appearance, resembling the cells of the granulosa cell layer of the ovarian follicle. It is believed that the histogenesis of this tumor is from the ovarian mesenchyme. Grossly, granulosa cell tumors are most commonly lobulated masses of brownish gray tissue with a glistening capsule. Yellowish discoloration is frequently found in portions of the tumor as the result of luteinization. Cystic cavities may be present throughout the tumor mass. Various histologic patterns have been described in the reported cases.

The usual clinical picture associated with granulosa cell tumors is some exaggeration of feminization resulting from the increased production of estrogen. When the tumor develops in the pre-adolescent years, sexual precocity is noted, and uterine bleeding may occur. When these tumors develop in the reproductive period, there is usually profuse menstruation, periods of anovulatory bleeding, or rarely long periods of amenorrhea. Due to the depressing effect of the high estrogen levels upon the pituitary, pregnancy is rarely associated with granulosa cell tumors; only a few such cases have been reported in the literature⁴. In the postmenopausal period, irregular bleeding is usually observed. The occurrence of postmenopausal bleeding associated with an ovarian tumor is very suggestive of a granulosa cell tumor. There appears to be a wide variation in the secretion

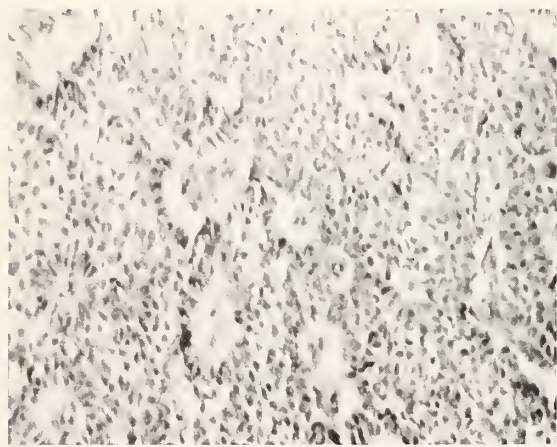


Fig. 1. Granulosa cell tumor showing follicle-like pattern.

of estrogen and clinical effects produced by tumors of similar histologic structure.

Granulosa cell tumors, like other dysontogenetic and embryonal neoplasms, possess a marked degree of malignant potentiality. Followup records reveal recurrence as granulosa cell carcinoma in more than 25 per cent of the cases⁵. Not only are these tumors in themselves frequently malignant, but they are frequently associated with endometrial carcinomas. An incidence of about 20 per cent coexisting carcinoma of the endometrium has been reported with granulosa cell tumors⁶. This observation appears to indicate that the increased production of estrogen is an important carcinogenic factor, at least so far as the endometrium is concerned. Also, a high incidence of carcinoma of the breast has been reported in association with granulosa cell tumors⁶.

The treatment of granulosa cell tumors varies with the age of the patient and the extent of the neoplasm. Since malignancy frequently occurs in these tumors in older women, but rarely in younger women, conservative surgery is recommended for younger individuals. In women past 40, total hysterectomy and bilateral salpingo-oophorectomy are highly recommended. The role of irradiation in the treatment of the granulosa cell tumors has not been established.

Case II. Thecoma

This patient, a 55-year-old white gravida III, para III, was first seen July 24, 1948. She had ceased to have regular menstrual periods four years previously, but had irregular bleeding since that time; it was never profuse, and for intervals as long as six months, no bleeding occurred. At the time of the first examination, the general physical examination was negative, but the uterus was irregularly enlarged, movable and firm. No adnexal tumors or other abnormalities were found. Vaginal cytology did not reveal malignant cells. The diagnosis of multiple uterine myomas was made; also endometrial carcinoma was suspected. She was not seen again until November 29, 1949, at which time there appeared to be a slight increase in the size of the uterus. Again vaginal cytology did not reveal malignant cells, and no adnexal tumors were discovered by examination. Curettage and further surgery were advised, but were

not done until September 18, 1950, which was six years after the menopause, during which time there had been periods of irregular uterine bleeding with remissions lasting from three to six months. At this time, a total hysterectomy and bilateral salpingo-oophorectomy were performed. The gross and microscopic findings on the surgical specimen are as follows:

The specimen consisted of a complete uterus, both tubes and both ovaries. The uterus measured 11 x 6 x 5 cm. The cervix showed no significant gross lesions. The endometrium presented a roughened shaggy appearance. Several small cystic inclusions of adenomyosis, one measuring 7 mm. in diameter, were seen. In one cornu, there was an isolated area of adenomyosis measuring 3 cm. in diameter. In the opposite cornu, there was a myomatous tumor nodule measuring 2.5 cm. in diameter, and a few small myomas were present in the myometrium. The Fallopian tubes and ovaries presented no unusual features in their gross appearance except that on section of the left ovary, there was a soft yellowish solid nodule 1.5 cm. in diameter.

Microscopic examination showed the endometrium to be proliferative in type and polypoid as a result of hyperplasia. One area of atypical hyperplasia of the endometrium was encountered. Extensive adenomyosis was found throughout the myometrium, and a section of a myoma showed the usual histology of these tumors. The Fallopian tubes and cervix were not abnormal. The nodule noted in the ovary was found to be composed of elongated connective tissue-like cells having ovoid nuclei. In some areas, these cells showed transformation into large luteal cells. (Fig. II.) Fat stains of the tumor demonstrated considerable intracellular fat in both the connective tissue-like cells and in the luteal-like cells. The histologic structure of this tumor identified it as a thecoma showing areas of luteinization. *Pathological Diagnosis*: Thecoma of ovary, hyperplasia of endometrium, adenomyosis of uterus, fibromyomata of uterus.

Case III. Thecoma

A 7-year-old girl with a history of vaginal bleeding for one month was seen by Dr. Walter B. Christophel of Mishawaka, Indiana, in 1928. Physical examination revealed a firm movable

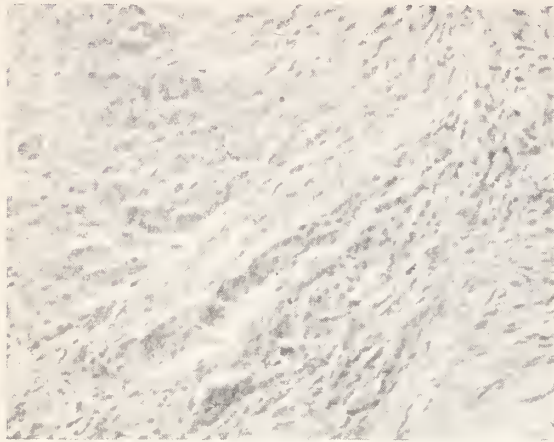


Fig. II. Thecoma showing areas of luteomatous transformation.

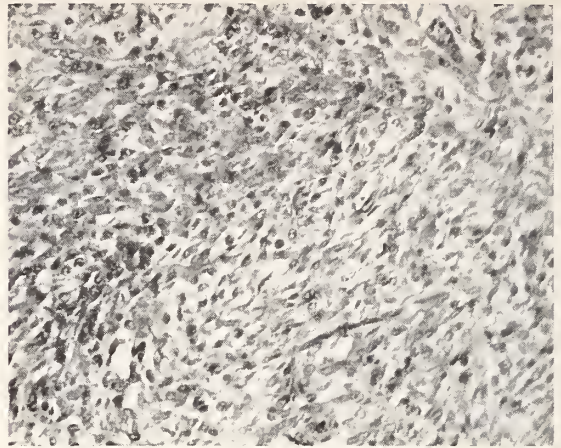


Fig. III. Thecoma showing connective tissue pattern of this tumor.

pelvic mass which extended to the level of the umbilicus. There was marked enlargement of the breasts and other signs of precocious sexual development. The tumor was removed February 27, 1928. It consisted of a solid tumor mass approximately 30 cm., in its greatest diameter and weighing 450 gm. It arose from the area of the left ovary. Since functioning ovarian tumors were not recognized at that time, this tumor was considered to be a sarcoma of the ovary. The child made an uneventful recovery with subsequent normal sexual development and became pregnant. Following the recognition of functioning tumors of the ovaries, this case was restudied by Dr. A. S. Giordano of the South Bend Medical Foundation and classified as a thecoma. The histologic characteristics of this neoplasm are shown in Fig. III. The tumor appears to have a high fat content in the hematoxylin-eosin stained slides, but gross tissue was not available for the demonstration of fat by special stains.

Comment (Thecoma)

Thecomas are less common than granulosa cell tumors. Two hundred and sixty-three cases have been reported². The histogenesis and physiologic effects of the granulosa cell tumors and thecomas, which is feminization, appear to be identical, and both tumors occur more commonly in older women. The histogenesis of the thecoma is unsettled; Novak⁷ and others believe that it belongs to the common histogenic group with granulosa cell tumors, and that since many of these tumors are histologically an admixture

with granulosa cells, they should be considered in one group as feminizing tumors. But since many thecomas are of pure histologic character, that is, composed entirely of thecal cells, some investigators consider them to be histogenic entities⁸. Thecomas have been produced in mice and rabbits by x-ray.

Irregular postmenopausal bleeding was the only symptom in the first case reported. The associated pathological findings of endometrial hyperplasia and the area of atypical hyperplasia simulating early malignancy parallel those of the other reported cases of thecoma. The treatment of these tumors in older women is total hysterectomy and bilateral salpingo-oophorectomy, but the occasional tumor of this type found in younger individuals, as in the second case reported, may be treated by more conservative surgery.

Case IV. Arrhenoblastoma

This 41-year-old white para I, gravida I, was first seen October 12, 1951. Her only complaint at that time was amenorrhea of six months duration. The general physical and routine laboratory examinations were negative. Pelvic examination was negative except for slight enlargement of the right ovary which was considered to be caused by a small cyst. She was given estrogen, as stilbesterol 1 mg. daily, for a period of one month, at the end of which time there was some vaginal bleeding—probably estrogen withdrawal bleeding. When next seen, March 13, 1952, she had lost 40 pounds, and menses had not resumed. There were no voice changes,

and the patient did not notice any decrease in the size of the breasts. She also stated that there was an accentuation of the normal feminine libido. On examination, there was found a cystic tumor arising in the pelvis which was about the size of a full term pregnant uterus. There was a marked growth of hair on the legs and face, (Fig. IV). The clitoris was definitely enlarged, (Fig. V). Four days after this examination, March 17, 1952, the patient had sudden severe generalized abdominal pain and vomiting. Obviously rupture or torsion of this huge cyst was suspected. At an emergency laparotomy, there was a small amount of clear fluid in the peritoneal cavity with a generalized inflammatory reaction of the peritoneum. On the anterior surface of the cyst was a necrotic area from which fluid was exuding. A trochar was inserted into the cyst, and an estimated 5,000 cc. of fluid was withdrawn. A right salpingo-oophorectomy was performed. The pathological report of the surgical specimen is summarized as follows:

The specimen consisted of a collapsed cyst having a roughened inner lining and a smooth external surface. This tissue which represented

the solid portion of the tumor weighed 610 gm. A Fallopian tube which appeared normal was attached to the surface of the cyst wall. The cut section of the cyst wall showed it to be composed of soft yellowish tumor tissue.

Microscopic examination, (Fig. VI) showed the tumor cells to be darkly basophilic and in much of the tumor, they proliferated as solid cell masses without characteristic architectural formations. In other areas, the cells showed an ill-defined tubular arrangement consistent with an arrhenoblastoma of intermediate type. Mitotic figures were rarely observed. *Pathological Diagnosis:* Arrhenoblastoma showing cystic degeneration.

Two months following removal of the tumor, regular menstrual periods occurred, although hirsutism and enlargement of the clitoris persisted. At this time, a determination of the 24-hour 17 ketosteroid urinary excretion was made and showed a total excretion of 9.5 mg. expressed as dehydro-isoandrosterone which is within normal limits.

Case V. Arrhenoblastoma

At a routine college entrance examination in 1934, this 18-year-old girl was found to have



Fig. IV. This growth of hair occurred following shaving one week previously. Marked hirsutism was also present on the legs.



Fig. V. Hypertrophy of the clitoris in Case IV—arrhenoblastoma.

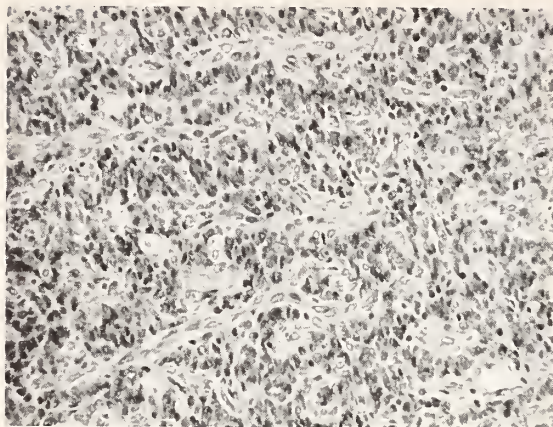


Fig. VI. Arrhenoblastoma showing imperfect tubular formation.

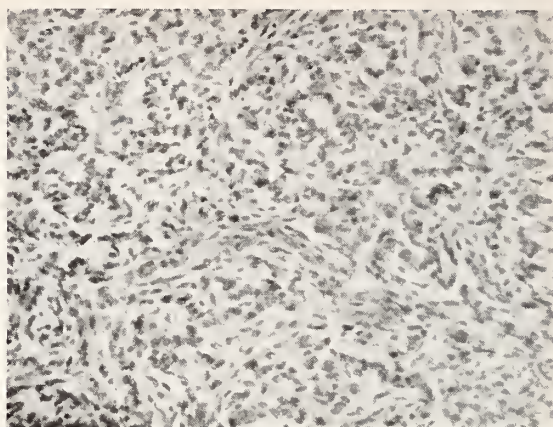


Fig. VIII. Arrhenoblastoma showing columns of cells and abortive tubule formation characteristic of intermediate variety.

a firm pelvic tumor which was palpable abdominally. She returned to her home for removal of the tumor, and her family physician, Dr. M. S. Teter of Middlebury, Indiana, observed the marked hirsutism, (Fig. VII). This finding with a noticeable low pitch of the voice enabled the pathologist, Dr. A. S. Giordano, to make a diagnosis of arrhenoblastoma preoperatively—an interesting observation since not many of these tumors had been reported at this time. At operation, a tumor about 15 cm. in diameter which arose from the left ovary was removed with the tube. The following is the pathological report:

The specimen consisted of a cystic tumor mass measuring 12 x 11 x 8 cm. On cut section, there were numerous cystic areas containing brownish fluid and being for the most part thin-walled. There were some tumor-like nodules in the cyst walls which varied from grayish yellow to reddish yellow in color and which were firm in consistency.

Microscopic examination of the tumor, (Fig.



Fig. VII. Marked hirsutism in 18-year-old girl with arrhenoblastoma.

VIII) showed the solid tumor nodules to be made up of epithelial-like cells resembling individually the cells of a granulosa cell tumor, but growing in a well-defined tubular pattern. In addition, there were seen nests and strands of large eosinophilic cells resembling interstitial cells of Leydig. *Pathological Diagnosis:* Arrhenoblastoma.

Regular menstruation resumed a few months following removal of the tumor, and the patient has had three normal pregnancies. The hirsutism persisted to some degree for about three years. The male voice characteristics have never entirely disappeared, although the tumor was removed 18 years ago.

Comment (Arrhenoblastoma)

Arrhenoblastoma is a rare ovarian neoplasm, not more than 125 cases having been reported. The first case here reported is unusual in that it is probably the largest tumor of this type that has come under observation. The clinical signs produced by these tumors are variable. There may be only the presence of a pelvic tumor without signs of defeminization. The effects of the endocrine function of this tumor may be merely defeminization, usually amenorrhea, or there may be signs of marked masculinization such as hirsutism, voice changes and enlargement of the clitoris. There seems to be no correlation between the size or histology of the tumor and the degree of the masculinization. In Case IV, normal female libido was increased and not decreased as might be expected, although increase in libido has also been observed

following the therapeutic administration of androgens. Pregnancy has occurred simultaneously with the tumor in a few cases, and has occurred following conservative surgery for arrhenoblastoma with the same frequency as following unilateral salpingo-oophorectomy for any condition. The incidence of malignancy, although not accurately determined, has been reported as about 20 per cent in all of the reported cases⁹. Recurrence and metastasis have been known to take place early, and also as long as 10 years after removal of the primary tumor. The 17-ketosteroid excretion determination may prove of value in detecting the development of a recurrence following removal of these tumors, although sufficient investigation has not been made to determine the value of the test.

Treatment of this tumor varies with the age of the patient and the extent of the tumor growth. In younger women with unilateral, non-adherent tumors and few signs of masculinization, unilateral oophorectomy may be adequate. If histological examination reveals a poorly differentiated type of tumor, the remaining pelvic organs should be subsequently removed. In the more extensive cases, and especially in older women, total hysterectomy and bilateral salpingo-oophorectomy is advisable.

Summary

1. Three cases of feminizing tumors and two cases of arrhenoblastoma of the ovary are reported.

2. Comments regarding histogenesis, clinical effects, pathology and therapy of these hormone producing tumors are included.

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PRESENT STATUS OF RADIOACTIVE COBALT THERAPY

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RADIOCOBALT or Co^{60} is an important addition to the list of physical agents available for effective radiation therapy of malignant disease. Certain articles on "Atomic Medicine" in the lay press have fostered the erroneous belief among patients that this form of therapy supercedes in effectiveness all existing forms of radiation. This unfortunate publicity has brought many inquiries to practicing physicians from cancer victims, and has deluged those engaged in the much needed clinical evaluations of Co^{60} therapy with requests for treatment. To provide a better perspective of its possibilities, this article will briefly review the development of this new radiotherapeutic tool.

Biologically, there is little evidence to substantiate that cancer is destroyed more effectively by one source of radiation than another when equal tissue doses are administered in a similar overall time period. More important to curability is the histological type of cancer, its site of origin, and the skill of the radio-therapist. The advantageous physical attributes of some sources of radiation, however, may offer a simpler, more direct, and better tolerated approach to certain therapeutic applications than can be duplicated by other forms. The advantage, if any, of one form over the other is therefore physical, not biological.

The great value of radium element and radon for intracavitary therapy and interstitial application is well established. The quality of its gamma ray emission (equivalent to 2-million volt x-rays) makes its employment desirable for teletherapy in the form of "radium bombs". Such use, which requires large quantities for an adequate time-dosage relationship has been prevented by its relative scarcity and high cost. A constant search has resulted for a cyclotron

or pile-produced radioactive isotope which might serve as an ideal low-cost substitute for radium.

According to Wilson¹, an artificially produced radioactive element would have to meet the following requirements to qualify as an ideal substitute for radium: (a) it must emit hard gamma rays; (b) it must have a long half-life; (c) it must be easily produced, in considerable quantities and with an adequate amount of radioactivity per gram of material, and (d) it must have the adequate physical properties for convenient therapeutic use.

The radioisotope of cobalt with an atomic weight of 60 and half-life of 5.3 years closely approximates these requirements. It is easily produced in the neutron pile at relatively low cost. It disintegrates by emission of a relatively soft beta radiation of 0.3 MEV energy, which is easily filtered out, and an almost homogenous gamma radiation of 1.16 to 1.31 MEV. This gamma ray energy is so close to that of radium that the therapeutic dosage problem is similar. Only about four per cent of the energy emission of cobalt 60 is beta as compared with seventy per cent beta emission in radium. Other properties of advantage to the therapist are listed below:

1. Solid and unbreakable; easily machined to desirable form.
2. Will not leak—no radioactive gases generated in its disintegration into nickel.
3. Magnetic qualities permit easy remote handling of small units.
4. Rapid elimination of any isotope accidentally entering the body.
5. May be produced at moderate cost in special forms to facilitate interstitial implantation.
6. Decreased activity may be "recharged" in a nuclear reactor.

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There are two major disadvantages of Co^{60} that make it unlikely that it will completely replace small quantities of radium used in every day practice. The first involves the complications and laboratory determinations incident to obtaining and using it. The second is the shorter half-life which requires recalculation of the dosage in gamma roentgens per unit of time at frequent intervals.

Nevertheless, to the therapist who is fortunate enough to have the facilities of a physics laboratory at his disposal, radiocobalt offers the possibility of greater flexibility and accuracy in the physical planning of treatments for difficult tumor problems than would be possible with usual radium needles and tubes of fixed linear density and construction. Thus with non-uniform loading of needles with cobalt and by using guiding templates, Morton² and his associates have adapted interstitial implantations to the individual needs of certain patients with pelvic cancers. Using this method, a more uniform distribution of radiation has been achieved than might technically be possible with the fixed sizes and lengths of radium ordinarily available. Similarly, some³ isotope laboratories have produced cobalt 60 beads of 3 or 4 mm. diameter with activity equivalent to 50 or 100 mg. of radium for use in intracavitary irradiation of the bladder, maxillary sinus, nasopharynx, middle ear and uterine cavity. Such a point source of radioactive material offers easier and more accurate dosage calculation, and is useful where lack of suitable forms of radioactive sources force one to depart from ideal requirements in treatment planning.

The need for flexible linear radiation sources to follow the contours of irregularly shaped tumors, prompted Morton, Callendine and Myers⁴ to devise a fine nylon tubing containing multiple small units cut from cobalt 60 wire. These radioactive nylon threads can be implanted into any site which can be reached by a surgical needle either from the body surface or during surgical procedures, and can be sewn throughout the contours of the tumor infiltration. Upon completion of the treatment, the radioactive threads are removed like sutures. This method offers more uniform radiation of tumors about the head and neck than afforded with radon seed implantation, and greater comfort to the patient than with rigid needles. Furthermore, once removed, the nylon threads can be heat

or chemically sterilized so as to allow repeated use. This technic also requires the facilities of skilled physicists, and will be of restricted use unless made generally available through radium supply houses⁵.

Radiocobalt will probably find its greatest usefulness for teletherapy with the so-called "cobalt-bombs"⁶. This application serves as an alternative to radium bombs or supervoltage x-ray generators. The few cobalt 60 units now operating show an output of 21.5 r per minute at a distance of 1 meter with a 6 x 8 cm. field and give a dose of fifty-six per cent at 10 cm. depth in the tissues. A multicure cobalt unit of this kind emits gamma rays of essentially monochromatic 1.2 MEV energy and compares favorably with existing supervoltage x-ray generators of about the 2-4 million volt range.

With the opening of the nuclear reactors at Chalk River, Canada and Arco, Idaho, Co^{60} is being produced with sufficiently high specific activity to contain several kilocuries in a single unit. Cobalt 60 from these reactors has 20 to 50 times greater gamma ray output per unit volume than radium. Up to present, only three large-scale sources have been produced at Chalk River, two for Canadian use and one for the Oak Ridge Institute. The higher proportion of radioactive material in the targets of these units is expected to more than double the roentgen output and allow the use of a smaller focal spot source, thus largely correcting the two major disadvantages which the first cobalt bombs showed in comparison to multimillion volt x-ray machines. The 1,100,000 curie Co^{60} unit at Saskatchewan gives a depth dose equivalent to that produced with an x-ray machine operating at a peak energy of 3 million volts and an output of 33 r per minute at 80 cm. distance⁷. The Co^{60} unit now operating at London, Ontario has sufficiently intense output to permit the fullest utilization of therapy in which the patient is rotated under the beam and permits rays to enter the tumor area through an arc of up to 360 degrees.

It should be pointed out that the increased cost of skilled professional and technical personnel, as well as housing and maintenance, place this type of therapy beyond the means of the average individual or hospital.

Summary

Co^{60} exerts its effects on cancer by the same type of gamma ray energy as is obtained from radium and supervoltage x-ray generators. Bio-

logically it offers nothing new or mysterious; it matters little to the cancer cell what type of gamma ray energy strikes it. Physically and economically, however, Co^{60} offers a new therapeutic tool for cancer treatment. From the economic standpoint, radiocobalt is only a fraction of the cost of an equivalent amount of radium. This saving is many times offset, however, by the need for elaborate laboratory equipment and trained personnel to process it into utilizable form. The total cost of installation of a "cobalt bomb" is about one-half of the cost of multimillion volt x-ray therapy equipment.

Physically, cobalt 60 offers a desirable and narrow gamma ray spectrum with low beta output, making it equal if not superior to radium except for the nuisance of its shorter half-life. In small quantities, its low cost allows one to make it up with enormous flexibility of form permitting the radiotherapist to meet the physical requirements of a difficult treatment case more ideally. Since such forms of Co^{60} are not commercially available such use will be restricted to such laboratories having the facilities to fabricate and properly calibrate the material.

The higher specific activity per gram of Co^{60} now available from nuclear reactors practically assures that the most practical use will be in the form of multicurie cobalt bombs. In comparison with supervoltage x-ray machines beyond 1-million volt capacity, the cobalt 60 unit costs less initially and for upkeep, is more compact and maneuverable and has a much more homogeneous beam. No filtration is necessary, a higher depth dose is obtained and the output is constant. The development of cobalt bombs of this type is still in its infancy, and such units are not generally available. The first bomb of this type was recently put into use in Canada

and has suffered from exaggerated statements in the lay press concerning its biological effects. It would be fallacious to conclude that any patient requiring radiation therapy would attain a better result if treated by cobalt 60. One form of X or gamma radiation excels physically over another only to the extent in which it can be more efficiently administered to that particular patient. In fact then, certain forms of cobalt 60 offer certain advantages for certain lesions. Although the technical advances made possible by radiocobalt are already apparent, it will be several years before adequate evaluation of the clinical results is available. Only then will cobalt 60 find its proper place in radiation treatment of cancer.

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SHOULD PATIENTS BE TOLD WHEN THE DIAGNOSIS IS CANCER?

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IN THE May-June, 1949, Vol. 1, No. 2, issue of *The Cancer Bulletin*, there appears a quotation from Oliver Wendell Holmes as follows: "Beware how you take away hope from any human being . . . it is the height of cruelty and the extreme of impertinence to tell your patient he must die, except that you are sure he wishes to know it, or that there is some particular cause for his knowing it."

Patients accept the diagnosis of an incurable disease such as arteriosclerosis, diabetes, and hypertension with ease and usually with determination to "stick it out." However, a diagnosis of cancer, which does have a certain percent of curability, is received with such gloom that the decision to tell a patient is at times a big one. Fear of the disease, fear of the mode of treatment, and fear of the possible outcome in the event of failure of treatment are the causes for the patient's disheartened attitude. Education of people by every possible means must be done to counteract this. The best work can be done by the doctors themselves in their everyday contact with their patients.

When cancer of any type is discovered and proved in an individual, the family physician is immediately confronted with a tremendous problem. If cure is impossible, then the physician must do all in his power to keep the patient living as long and as comfortably as possible and still stay within the limits of the desires of the patient and the patient's family. Should the patient be told? Who should tell the patient? At what stage of the disease should the patient be told?

My personal opinion on this subject was that the patient should be told honestly but cautiously all that the physician has discovered. I believed that the family should first be consulted about the patient and about who should tell the patient; however, in actual cases on contacting the near relatives, almost always they desired that

the patient not be told because they did not feel that the patient could tolerate the fact that he had cancer. Because of the complexity of the problem, because it so closely involved the patient-doctor relationship, because of the desire to know absolutely the best procedure to follow, and because of my inability to find any conclusive answers from the literature with reference to this problem, I decided to conduct a patient survey just to find out what the patients and their near relatives (at least in this vicinity) would like to know, should they be afflicted with cancer of any type.

Since the survey, my opinion has changed only insofar as insisting that the patient be told but that plenty of time be taken to explain to the family why the patient should be informed. (Occasional exceptions are noted at the end of the paper). One should explain to the family that if the cancer is in a stage where a cure is possible by surgery or any other means, then the patient should understand why he will be subjected to the type of treatment advised by his physician. If the cancer is incurable but can be improved, then the patient should understand the reason for the type of treatment he is getting. It should be explained to the patient that the relief may be only temporary, that the treatments may have to be repeated, and that perhaps eventually the treatments will do no good. Then as the patient continues to get worse, he will understand why he is getting worse and not bear hard feelings toward the doctor, the family, or friends who would ordinarily keep telling him that he is doing fine and that he will get better in time. The patient will get less depressed, will not lose confidence in those whom he has always trusted and he will not flit from doctor to doctor and hospital to hospital; and very often from "quack to quack", spending more and more money for less and less help and gathering more ill will along the way.

It has been my experience that a patient who understands his problem will cooperate much better in any type of treatment and will feel much more relaxed towards his situation. If the eventual outlook is hopeless, he will have ample time to get his numerous legal items such as property, insurance, bills, etc., in order while he is still physically and mentally fit to think carefully and adequately for the care of those whom he may leave behind. It gives the patient a chance for more intense religious preparation and this certainly is a great help to the physician in handling the problem.

It should not be overlooked that if cancer has been cured by adequate treatment or if the results have been excellent even towards lengthening of life and making life more comfortable, then the physician's relationship with the patient, his family and friends, has not been strained and the medical profession's public relations with the laity has been greatly improved.

The questionnaire reproduced below and devised to provide the above mentioned information as well as a few other related questions, was distributed to approximately 1000 individuals. After a reasonable length of time, 477 questionnaires were returned with answers. The questionnaire is as follows:

CANCER QUESTIONNAIRE

Otis R. Bowen, M.D.
Bremen, Indiana

A doctor faces a difficult problem when he discovers cancer in one of his patients. Should he tell the patient? Or should he try to make the patient believe that no cancer exists? Opinions among doctors differ and certainly opinions among patients must also differ as to the best procedure to follow.

To my knowledge there has never been an extensive patient-survey made as to what the individual desires might be with reference to one's personal knowledge of cancer. I am attempting to make such a survey and believe with your honest answers these problems may be more intelligently faced by your doctor and yourself. Please do not consider the questions in any way related to any condition that you may be under treatment for at the present time. This is intended to be an impartial general survey. Please consider the questions carefully and give your own personal feelings toward this subject.

It would be helpful and interesting to know if opinions differ as to age groups, sex, occupations,

and religion; therefore, I am asking you to fill in the blanks accordingly.

Age----- Sex----- Occupation-----

Religion-----

1. If your doctor discovered that you had cancer, would you like to be told about it? Yes---- No----

Why? -----

2. If your doctor discovered your wife, husband, father, mother or other close relative had cancer, would you like for them to be told? Yes---- No----

Why? -----

3. Do you think it possible completely to fool the patient with cancer by telling him he does not have cancer? Yes---- No----

Why? -----

4. Who do you think should tell the patient he has cancer? The doctor----- The minister-----
Close relative-----

Why? -----

Thank you very kindly for your answers. I assure you that individual answers will be kept confidential, but will be studied carefully as a group.

You may or may not put down your signature. It is completely voluntary. If you do not put down your signature, please be sure that the questions with regards to age, sex, occupation, and religion are answered.

Signature -----

Sincerely yours,

Otis R. Bowen, M.D.

Tabulation reveals the facts as noted in the charts. Even though 477 questionnaires were answered, the figures will not always total 477 because some of the individuals apparently preferred not to, or were unable to answer some of the questions. All 477 answers were from the white race.

SEX-AGE GROUPS

Age Groups	18 to 35	36 to 50	51 to 65	66 to 90	Total
Men	100	61	45	20	226
Women	126	58	46	21	251
Total	226	119	91	41	477

OCCUPATION-SEX-AGE-GROUPS

OCCUPATION	MALES					FEMALES					Grand Total
	18 to 35	36 to 50	51 to 65	66 to 90	Total	18 to 35	36 to 50	51 to 65	66 to 90	Total	
Age Groups	35 to 50	51 to 65	66 to 90			35 to 50	51 to 65	66 to 90			
Farmer	18	16	17	6	57	0	0	0	0	0	57
Business & Professional	23	21	14	4	62	10	7	4	0	21	83
Laborer	46	16	14	6	82	4	0	3	0	7	89
Domestic	1	1	0	0	2	104	51	39	19	213	215
Student	12	0	0	0	12	0	0	0	0	0	12
Total	100	54	45	16	215	118	58	46	19	241	456

RELIGION-SEX-AGE GROUPS

RELIGION	MALES					FEMALES					Grand Total
	18 to 35	36 to 50	51 to 65	66 to 90	Total	18 to 35	36 to 50	51 to 65	66 to 90	Total	
Age Groups	35 to 50	51 to 65	66 to 90			35 to 50	51 to 65	66 to 90			
Protestant	83	52	34	20	189*	111	53	43	21	228*	417
Catholic	6	2	1	0	9	5	5	1	0	11	20
Jewish	1	0	0	0	1	0	0	0	0	0	1
Total	90	54	35	20	199	116	58	44	21	239	438

* Includes 11 Amish and 1 Christian Scientist

* Includes 17 Amish and 1 Christian Scientist

Expression of answers to the questions on the questionnaire can also be more easily and completely shown in chart form, but in order to conserve space a resume of probable conclusions only will be given. Anyone desirous of the complete tabulation may obtain them from me.

Question One

If your doctor discovered that you had cancer, would you like to be told about it?

Probable conclusions from tabulation of results:

1. 96.6% of all persons regardless of sex, age, occupation, or religion desire to know whether or not they have cancer.

2. 99.8% of all people surveyed have a definite opinion.

3. The age group 18 through 35 represents 48% of those who answered this question; only .9% of this age group desired that they not be told if they were found to have cancer. In contrast, 5.2% of age group 36 to 50, 4.6% of age group 51 to 65, and 7.5% of age group 66 to 90 gave a negative answer. This seems to indicate that the younger group prefers the total truth concerning their condition more than the older age groups.

4. Of the 15 persons expressing a negative answer, ten were women and only five were men, indicating the probability that men are more apt to prefer the straight facts than women.

5. The survey did not reveal any correlation between the desire to know or not to know and the occupation or religion.

Question Two

If your doctor discovered your wife, husband, father, mother or other close relative had cancer, would you like for them to be told?

Probable conclusions from tabulation of results:

1. 88.6% of all persons regardless of sex, age, religion or occupation desired that their close relatives be informed if they are afflicted with cancer in contrast to 5.7% of all persons surveyed desiring that their close relatives be spared the information. This contrasts with 3.2% of the individuals personally having no desire to be informed if they themselves were afflicted.

2. 94.3% of all persons surveyed had a definite opinion on this question, while in Question One when the individual was more concerned, 99.8% had a definite opinion. In other words there was more indecision apparent when close relatives rather than one's self were concerned.

3. Of the 26 desiring that their close relatives be spared the information of their affliction, 13 were men and 13 were women. 4.4% of age group 18 to 35, 6.1% of age group 36 to 50, 7% of age group 51 to 65, and 7.5% of age group 66 to 90 gave negative answers. This shows a progressive tendency the older the group the more the reluctance to tell their close relatives of their condition. In comparing percentages of negative answers of Question One (involving personal knowledge) and in Question Two (involving knowledge for close relatives), there is a greater desire to have personal knowledge than to have a knowledge of cancer imparted to their close relatives.

4. There is no correlation between answers to Question Two and occupation, or religion of persons surveyed.

Question Three

Do you think it possible completely to fool the patient with cancer by telling him he does not have cancer?

Probable conclusions from tabulation of results:

1. 12.3% regardless of age, sex, occupation or religion (14% of males and 10.7% of females) thought that patients could be fooled; 6.8% (8.4% of males and 5.4% of females) were undecided and 80.9% (77.6% of males and 83.9% of females) said that patients could not be fooled.

2. 13.9% of age group 18 to 35 (18% of males and 10.6% of females) said patients could be fooled.

3. 6.1% of age group 36 to 50 (5% of males and 7.4% of females) said patients could be fooled.

4. 15.1% of age group 51 to 65 (17.5% of males and 13% of females) gave a positive answer.

5. 15% of age group 66 to 90 (15% of males and 15% of females) said yes.

6. 76.9% of age group 18 to 35 (72.3% of males and 85.2% of females) said that patients could not be fooled.

7. 86% of age group 36 to 50 (86.7% of males and 85.2% of females) said no.

8. 76.7% of age group 51 to 65 (75% of males and 78.3% of females) said no.

9. 82.5% of age group 66 to 90 (80% of males and 85% of females) said no.

10. Of all ages, regardless of occupation or religion, fewer women than men feel that a cancer patient can be fooled into thinking he does not have cancer.

11. The age group 36 to 50 represents the most suspicious age group; this is the only particular age group in which fewer males than females said patients could be fooled.

12. More women than men are willing to express a definite answer.

13. There is no correlation between the occupation and religion with regards to the answers of this question.

Question Four

Who do you think should tell the patient he has cancer? The doctor? The minister? A close relative?

Probable conclusions from tabulation of results:

1. 85% of all individuals (82.3% of males and 88% of females) regardless of age, sex, religion or occupation prefer that the doctor alone tell them they have cancer.

2. 91.3% (88.4% of males and 93.4% of females) of all people surveyed stated that the doctor should either tell or be a partner in telling the patient about his condition.

3. 95.9% (93.6% of males and 97.9% of females) of all those who expressed an opinion, stated the doctor should be at least one of the informers.

4. 1.5% (2.3% of males and .8% of females) of all persons surveyed regardless of age, religion, or occupation preferred that their minister inform them or their close relatives of their affliction with cancer if they ever become so afflicted.

5. 2.4% (3.7% of males and 1.2% of females) of all persons surveyed gave as their preference a close relative.

6. 2.6% (2.8% of males and 2.5% of females) preferred a combination of their doctor and minister.

7. 3.1% (3.3% of males and 2.9% of females) preferred a combination of a close relative and their doctor.

8. No one chose the combination of close relative and minister.

9. .65% (.5% of males and .8% of females) chose the doctor, minister and close relative combined.

10. 4.8% (5.1% of males and 4.5% of females) had no preference.

11. The minister is involved in a choice either alone, or with doctor in 4.8%, in comparison to close relative being selected either alone or in combination in 6.1% of all cases.

12. Broken down by age groups it is interesting to note the percentage which chose the doctor as the one most preferred to impart the information of cancer to the patient:

A) Age group 18 to 35

Doctor alone 88.8% (87.6% of males and 89.7% of females)

Doctor alone and combined 94.2% (92.8% of males and 95.2% of females)

B) Age group 36 to 50

Doctor alone 79.4% (76.8% of males and 82.1% of females)

Doctor alone and combined 86.6% (85.7% of males and 87.5% of females)

C) Age group 51 to 65

Doctor alone 83.5% (81% of males and 86% of females)

Doctor alone and combined 90.6% (85.7% of males and 95.3% of females)

D) Age group 66 to 90

Doctor alone 82.1% (75% of males and 89.5% of females)

Doctor alone and combined 89.7% (85% of males and 94.7% of females)

E) Study of the above figures reveals that, regardless of sex, the age group 18 to 35, that men of 18 to 35, and that women of 51 to 65 (only .1% greater than women 18 to 35) desired that the doctor be included in their choice, more than other groups to tell the patient that he had cancer; that regardless of sex, the age group 36 to 50 and that women of 36 to 50 and men of 66 to 90 (only .7% less than age 36 to 50 and 51 to 65) included the doctor as their choice the least of any of the age groups. Although the percentages are all within 10 points, there is a fairly definite pattern established. The group 18 to 35 seems to look to their doctor with trust and confidence in this matter more than other age groups and the age group 36 to 50 seem to show less tendency to trust their physician in this matter than other age groups.

Quotable Comments by Patients Surveyed

The reasons given for answers to the various questions show that much thought was given by many of the persons surveyed. The answers whether yes or no, more or less grouped themselves into six classes (some closely related) but were classified separately to bring out important points.

1. Emotional—expressing fear, worry, etc.

2. Financial—strictly a business proposition.

3. Moral—expressing the hope or demand for the truth.

4. Future — expressing determination for cure, thought of family, religious preparation for

death and arranging personal affairs for any eventuality.

5. Educational—expressing need for more or the value of that already received.

6. Relationship—expressing cooperation and good will between the patient, doctor, minister and family (closely related to the moral).

It is obviously impossible to include many quotable comments since they are tabulated according to thought groups (as shown above), age, sex, religion, occupation, question number, and whether the answer to the specific question was yes or no. A few of the patients' comments are included below as examples but without putting them in any special category. (Anyone desiring the complete information may have it by contacting the author.)

Age 26, female, Protestant, business and professional: "If I knew I had cancer, I might not live as happy a life. It would lower my spirits."

Age 50, female, Protestant, business and professional: "To relieve the torturing suspicion and fear. Knowing my condition I can seek means for a possible cure. If incurable I shall muster courage to prepare myself for the inevitable."

Age 39, male, Protestant, business and professional: "The shock of knowing wears off quicker than the uncertainty and continual worry and wonder."

Age 29, male, Protestant, laborer: "Who wants to be misled? . . . a person pays for a doctor's services just the same as one pays for a piece of merchandise—why misrepresent in either case? It does not pay."

Age 31, male, Protestant, laborer: "I'm paying the bills, I'd like to know the plain facts."

Age 41, male, Protestant, business and professional: ". . . answers are from Christian standpoint . . . deception is a lie and no liar has access to the kingdom of Heaven. Moral involvement necessitates the truth . . . there are often matters, both temporal and spiritual, that need adjustment before death comes . . . frankly, I have heard the complaint of deception lodged against doctors more than any other complaint against the medical profession."

Age 61, male, Protestant, laborer: "For the same reason that if he found I had measles, scarlet fever, or indigestion. That is what I go to a doctor for. I would not ask my doctor to lie to me."

Age 32, female, Protestant, business and professional: "I should like to face the truth squarely to be prepared for any eventuality. However, if the wishes of my family or the judgment of the doctor were to the contrary I would waive mine."

Age 51, female, Protestant, domestic: "Because I like the truth in all things—I like to face facts as they are—not live in a false security."

Age --, male, Protestant, business and professional: "Having a mutual understanding that I was nearing the end would enable me to be more of a comfort to my survivors. Having a false opinion that I was going to get well and yet feeling worse as time passed would put me in a mental agony I believe, an agony that would only add to my distress."

Age 41, female, Protestant, business and professional: "I would be optimistic that I could be cured. Also a cure might be found very soon with the amount of research going on all over the world—one could become optimistic over that alone. (I likely wouldn't be so stoical if put to test.)"

Age 26, male, Protestant, laborer (six serious operations after injuries of war): "Because I feel there is always a chance for recovery and more so if the person knows what he's up against. Most people won't sacrifice their wants for their needs when ill unless they know for sure what is wrong."

Age 61, female, Protestant, domestic (chronic lymphatic leukemia herself with knowledge of same and cooperating well—and doing well past five years): "Because if one knows it in time . . . there is greater chance of getting rid of it . . . and if one is not ready for death, he may think more of that preparation."

Age 47, male, Catholic, business and professional: "Unless the doctor is sure the patient can mentally adjust himself it is best the doctor does not tell until . . . the disease becomes hopeless and the patient realizes."

Age 33, female, Protestant, domestic: "They probably would guess it anyway, if not through

symptoms through concerned attitudes of relatives and friends. Certainty of it and one's faith would help more than the ravages of doubt brought on by knowledge withheld."

Age 41, female, Catholic, domestic: "Most patients have implicit faith in their doctor; therefore, no matter who else would tell him he would want the final word from his physician."

Age 37, male, Protestant, domestic: "The emotional stability of the patient should decide this question. Also the confidence she has in her doctor, the faith she has in her minister, and the closeness of the family."

Summary

A survey of 477 individuals between the ages of 18 and 90 was conducted to determine if patients desired to know whether or not they had cancer; whether or not they desired that their close relatives be told if they were afflicted with cancer; whether or not they actually thought individuals with cancer could be fooled into thinking they did not have it; and who they thought should tell the patient the diagnosis of cancer. Each person was asked to give a reason for his answer. In general the greatest number of people not only desired the truth to be told themselves but also desired that their close relatives be informed; a large majority did not feel that patients could be fooled; and an overwhelming number thought the doctor should be the one to tell the patient the facts about his or her illness. Many individuals expressed desire for cooperation between the doctor, minister, and close relatives in handling the situation. There was no great difference of opinion among age groups and sex but there was definite evidence that the age group 18 to 35 and that women more than men seemed to express greater trust and confidence in their doctor and that the age group 36 to 50 seemed more cancer conscious than other age groups. Answers did not seem to vary with occupations or religions, however, individuals of the business and professional group gave more extensive reasons for their answers.

After many hours of study and preparation of this report it is my opinion that the problem should be handled as follows and in the order listed:

1. First, be very positive of the diagnosis by rechecking and consultation.

2. Study the patient's background with reference to personality, religion, family life, etc., to determine whether or not you think he would be better off to be told outright or whether or not he would prefer a close relative or minister or both to assist in telling him.

3. Consult the nearest relative and explain in detail the diagnosis and why you think the patient should be told.

4. Tell the patient and explain in detail the diagnosis, the proof of the diagnosis, the type of treatment needed, how long the treatment will take, what he can expect from treatment, estimate of the cost of treatment, where he can seek aid if unable to cope with the problem and advise that he can get spiritual comfort and encouragement by confiding in his minister.

5. Talk with the patient's minister unless advised not to by the patient or his family. I have received excellent cooperation from every minister I have ever talked with concerning patients' problems and the patients and their families have been very grateful for this added service and understanding.

6. The following types of patients perhaps should not be told: those too young to understand; those mentally unfit; those few who have previously expressed their desire never to be told if they had cancer and perhaps a few of the very aged who have a malignancy known to be slow in growing and would not cause their demise before some other ailment.

Repeatedly patients expressed the desire for truth, conscientiousness, morality, trustworthiness, and a Christian attitude on the part of the doctor when handling not only the cancer problem but in all patient-doctor relationships. This, we cannot ignore.



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EXFOLIATIVE CYTOLOGY

IT IS NOW only ten years since Papanicolaou and Traut published their monograph on vaginal cytology in the diagnosis of uterine cancer. To say that this new "smear test for cancer" was first received with skepticism, particularly by pathologists, would be more than a mild understatement. Nothing testifies better, however, to the essential soundness of their contribution than the progressive reversal of the attitude of the profession towards the method from one of abject suspicion to one of enthusiastic approval. Not only has the basic principle of the technique been verified, namely, that cells exfoliated from a body surface would reveal by their microscopic characteristics whether that surface area was composed of normal cells or was the site of a neoplastic growth—but its usefulness has been extended to the diagnosis of neoplasms of body systems other than the female genital tract. Moreover, as evidence that such a test is practical, in a relatively few years a large number of pathol-

ogists have become expert in the interpretation of the smears primarily through the efforts of Doctor Papanicolaou and his staff and through the establishment of training fellowships by the American Cancer Society. That such a method would be followed by modifications was inevitable, and noteworthy among these have been the "surface biopsy" produced by scraping the squamocolumnar area of the cervix, and the adaptation of the paraffin section technique to sediments of the body fluids and exudates.

Despite exhaustive research, the cancer problem remains largely unsolved. Attempts at prevention and therapeutic advances are calculated in small percentage gains, even after several decades of experience. No simple biologic reaction which could be used as a universal test for the presence of cancer has been demonstrated, and the chances for such a discovery seem remote. Medical practitioners must therefore face the fact that progress in cancer control

has not advanced beyond the point where early diagnosis by morphologic methods remains the one salient variant in determining the chances of cure. While this may be disputed by some in other forms of malignant disease, it seems eminently true in the case of cancer of the cervix. This fact gives added significance to the observation which has been reported again and again by those who have used the method extensively, namely, that the use of the smear method will lead to the detection of cervical cancer at a time when it is impossible of demonstration by any other means. In this connection, the problem of intra-epithelial carcinoma of the cervix logically arises, but detailed consideration of this lesion is not germane to this presentation. However, the number of cases which have been reported wherein this lesion became or was associated with invasive carcinoma is now sufficiently large that any in situ lesion must be regarded as a potentially invasive growth.

Outside the field of gynecologic cancer, the method has had its greatest use in the diagnosis of bronchogenic malignancy. Fresh sputum or bronchoscopic aspirates reveal atypical cells in a high percentage of pulmonary cancers. Cancer of the stomach has resisted easy detection by the method, but a modification using an abrasive balloon to encourage exfoliation of tumor cells has given encouraging diagnostic results. An indirect benefit which any pathologist will readily admit is that after he becomes more observant in *cytologic* details demanded in smear study, he becomes more proficient by virtue of this discipline in *histologic* diagnosis.

The method should suffer no lack of support from the enumeration of a few of the limitations and pitfalls encountered in its use. It cannot be emphasized too strongly that all positive smears must be confirmed by a histologic (biopsy) diagnosis before radical therapy of

any type is instituted. This may be impossible in certain instances of inaccessible neoplasms, i. e., those in the smaller radicles of the respiratory tract. Conversely, a negative smear should not be an indication for cessation of further diagnostic procedures in a patient who presents clinical findings inconsistent with a negative report. In this regard, cases of endometrial cancer may not infrequently have negative smears. False positive smears though rare have and will continue to plague all concerned. Their relative number will decrease with the increasing experience of the cytologist—as will the number of the tormenting “equivocal” or “suspicious” reports. Pathologists responsible for reporting results of smear examinations must exercise caution lest their reports be misinterpreted and used as a basis for unnecessary operative procedures. Consultation between the pathologist and clinician should be the rule in the case of every positive or equivocal report.

Widespread use of the vaginal smear as a screening test for uterine cancer has been discussed in the literature at length with no resultant unanimity of opinion. Some believe the method too costly to be worthwhile as a screening procedure. More time and information are necessary for the resolution of this problem.

Barring the unexpected discovery of a simple biologic test for cancer, it appears safe to predict that cytologic methods will continue to serve as an increasingly important adjunct in its morphologic diagnosis. Because of the pioneer work of George N. Papanicolaou in formulating the principles and popularizing the method of cytologic diagnosis, countless women are alive today who would otherwise have died in the prime of their lives. This monumental contribution of Doctor Papanicolaou is worthy of more acclaim than it has received.

C. S. C.

FELICITOUS COOPERATION

THE RECENT symposium on cancer of the uterus presented March 4 by the Indiana University School of Medicine in cooperation with the Indiana Division of the American Cancer Society was one of the best meetings of its type we have ever attended. It was impressive be-

cause of the thoroughness with which its subject was covered. It was authoritative because of the caliber of its speakers. And, finally, there was a generous portion of “meat” for use in actual practice.

One aspect of the meeting which pleased us,

and which we feel was responsible for the high quality of the whole symposium, was the fact that none of the speakers "talked down" to the audience. There was perfect attention from the latter, and the questions they asked showed that doctors in general understand some of the technical points of pathology as well as those pertaining to clinical diagnosis and treatment.

The mild polemic between Dr. John McKelvey

and Dr. Norman Miller was in itself instructive in that it offered an insight as to the approach made by such top-notch men in solving clinical problems. Instruction in scientific method, and the resulting mental stimulation, is very good "medicine" for busy doctors long out of medical school. Our hat is off to all concerned in producing this symposium.

—A.W.C.

MEDICAL EDUCATION BY PRECEPTORSHIP

AT ONE TIME preceptorship was the best means of obtaining a medical education. It was practically the sole method for the propagation of medical knowledge for several hundred years prior to the development of medical schools.

As medical schools, with more and more highly organized didactic teaching, were evolved, and especially when bedside teaching in university hospitals became popular, training by preceptor became less and less necessary.

During the past few years medical educators in the United States have cautiously explored the possibilities of obtaining the advantages inherent in the preceptor system by introducing it in moderate doses into the regular medical curriculum.

In Indiana, committees of the Indiana State Medical Association, the Indiana Academy of General Practice and Indiana University School of Medicine have held several meetings to study the advisability and feasibility of such training in the medical school.

This type of training is in use in ten schools at the present time. Details of the various programs vary but usually the preceptorships are in general practice. One of the advantages of the system is the opportunity which it affords the medical student to acquaint himself with the rewards and satisfactions of general practice.

A survey made recently at I. U. School of Medicine showed that between 40 and 50 percent of the Junior class is interested in a preceptorship as a part of their fourth year training. It is thought that a period of from six to eight weeks should be devoted to this training. If the program is adopted it will be started as a pilot plan, in order to accumulate experience and eliminate the rough corners on a small scale at first.

The faculty council of the medical school is continuing its study of the proposal. If it is adopted it will provide a splendid opportunity for individual practitioners and the State Association to participate cooperatively in the education and indoctrination of future physicians.

NOW IS THE TIME

THE "BUSINESS AS USUAL" attitude of too many of our profession toward the relentless forces striving to wreck our economy with piecemeal socialistic legislation is hard to comprehend. Yet—with all the avenues of information transmission open for our use we find only a

scant word here and there that tells us "all is well." Few words there are, and hard to find, that analyze the portent of movements that are aimed at the obliteration of the patient-doctor relationship that has made American Medicine a historical success—until agitating voices (not

the patient's) fired with the atheistic hatred of Marx's delusions came along under the protection of a previous administration to pick flaws in every American tradition and create a defensive attitude on the part of the medical profession.

Does the majority of our profession acknowledge these accusations of negligence, incoordination and stupidity? I do not believe so. Why then the continued defensive strategy? Is the spirit and the will to fight for what is just and good not worth the effort? Out of 160,000 practicing physicians who could all make themselves heard—why is there but a handful willing to stand up and say “those ideas are morally wrong, we'll fight them so long as they exist.” While the card carrying communists, the fellow travelers, and the socialist planners devote 18 hours a day and half of their income to force their theories upon a time proven government of maximum human freedom, the professed upholders of American liberties refuse to add to their daily work a fraction of the time and money needed to combat the evil ideas that now inundate this nation.

One has but to follow the current legislation in Congress to know that a change in administration has been no guarantee of reprieve from collectivism. Hearings have been held on Section 3 of P.L. 590, which if passed will put Falk's plan for socialized medicine a step closer to its goal—National Health Insurance. The Socialist Republicans Ives and Flanders have introduced a “Voluntary” national health bill per I.N.S. release of 3/2/53. They say it is the

same as the AMA approved in 1949. It is a follow-up of the Magnuson Report which Baketel described as “not likely to influence people one way or the other.” AMA delegates will have discussed the President's Plan for elevating the F.S.A. to cabinet status on March 14. Will the common sense of those attending be influenced to silence on moral principles in the same manner that legislative matters of importance were handled at the Interim meeting? Elevation of F.S.A. is an extension of the powers of socialism. What are you going to do about it? The forces in command of current government are hedging on their promise to cut taxes which can easily be done by cutting out extraneous bureaucratic functions. How many of you are supporting the Reed tax amendment by writing to legislators? How many of you know about the Gwinn bill to take government out of private business—and what are you doing about that issue? Have you advertised the Bricker Amendment to safeguard our Constitution from U.N. treachery—or are you satisfied that the new Department of State will handle the matter for your best interests—and so forget the matter, and wait until you are hailed before a World Court for breaking U.N. laws?

The time to speak up for liberty is now. Your patients will thank you for the effort when they comprehend the full tragedy of what “planners” have in store for them. This is not the time for complacency, conciliation, and concurrence with wrongs—it is time now to stand up and fight for those things that America has proved to be right, just and honorable.

Editorial Notes

Fewer Applicants for Medical Schools

Continuing a three-year trend, the number of students applying for admission to the nation's medical schools declined again this year, according to the official study of 1952-53 applicants by John M. Stalnaker, director of studies for the Association of American Medical Colleges.

Results of the study, reported in the February issue of *The Journal of MEDICAL EDUCATION*, show that some 3,150 fewer persons applied this year than in 1951-52 and some 7,600 less than three years ago.

This means that competition among the medical schools for high-ranking student applicants is increasing. Of 16,763 persons who made application last fall, 7,778 were accepted.

Geographical distribution of applicants is uneven, with half of the applicants coming from seven states. This means some states have a wealth of students to choose from, while others find it impossible to fill all the places in their freshman medical classes with really first-rate students. The lack of qualified candidates can be serious in states that have residency requirements.

The survey shows that the average pre-medical student applies to three or four medical schools, so that no school can expect to have every student they select. One cautious student this year applied to 45 medical schools and was accepted by one.

Letter to the Editor

February 23, 1953

Frank B. Ramsey, M.D., Editor
Journal I.S.M.A.
201 Hume Mansur Bldg.
Indianapolis, Indiana

Dear Doctor Ramsey:

Alert sources were attempting to warn the medical profession of the dangers of Section 3 P.L. 590 last year and predicted that OASI Bureau would set up the machinery to implement that part of the law *for its continuation after June 30, 1953*. Recent testimony before a House Committee proves this prediction to be true. The committee was told, by the bureaucrats involved, that they were developing policies and procedures to administer the disability program, (which constitutes another step toward socialized medicine) and that 100,000 inquiries had already been received.

The time is overdue for the doctors of our association to inform their patients on the contemplated evil that would result from the continuation of this part of P.L. 590 in order that all may write to their legislators in objection to such an attempt to create socialized medicine.

Without this grass-roots disapproval, our legislators could very well vote a continuation of Section 3 P.L. 590, in the next several weeks.

Sincerely yours,
A. G. Blazey, M.D.
Washington, Indiana

A Plea for Freedom

February 16, 1953

Ever since the statistical analysis of the bed occupancy of veteran's hospitals showed that 64.5% of such cases were for non-service-con-

nected (n-s-c) disabilities, the spokesmen for various organizations interested in the continued participation of the federal government in the doctoring business have minimized that figure by clouding the issue with humanitarian talk about the bulk of that number being made up of T.B., N.P. and chronic cases. These cases, they argue, would have to be treated at state expense anyhow, and there are not sufficient existing facilities to handle them—therefore, it is justifiable for them to be cared for in veterans' facilities. By such dubious reasoning they automatically reduce the 64.5% figure to 14.4%, and then estimate that about 8% are receiving short-term medical care on the basis of professed inability to pay for the service elsewhere.

The fallacy in their lines of reasoning rests on their acceptance, as just, of 50.1% n-s-c chronic cases requiring federal medical care. If it is fair to provide housing, clothing, food and medical care at the hands of a welfare state to 497,000 ex-service men because of disabilities having no connection with the service they rendered—then it is also fair to provide the same "benefits" for 500,000 ex-government workers and their families. By the same process of dialectics, the welfare state could provide the same "benefits" for ever increasing numbers of privileged groups. The end result would be the current objective—SOCIALISM.

We cannot hope to have a return to sane, Constitutional, republican government unless special groups stop asking for federal "hand-outs" to relieve them of their individual responsibilities. The only reason we have the problem now, is because of shortsighted legislators in past years who thought that they could avoid the moral code by legalizing means of plunder.

When the proponents of such class legislation get down to thinking in terms of right and wrong, as is made perfectly clear by simple, basic, moral codes of living that have stood the test of time, and in terms of the loss of freedom that accompanies the perpetuation of these socialistic schemes, then we may have the long overdue repealing of laws that have for the past 40 years been gradually destroying the God-granted liberties established and recognized by our wise forebears.

A. G. Blazey, M.D.
7 East Walnut St.
Washington, Ind.

Medical Panorama *by the* ASSOCIATE EDITOR

AN INTERESTING NEGLECTED SUBJECT

Medicolegal matters are mostly relegated to the background of a doctor's consciousness, as though of no real consequence. Actually, this is a most important field and an interesting one. If you don't believe the latter, try reading "Scalpel of Scotland Yard,"—all about Sir Bernard Spilsbury. Our North Carolina colleagues take such matters seriously enough to promote a medicolegal symposium, which represents a distinct step forward in a rather neglected field. Perhaps we in Indiana could profit from such a program, as shown in the "quote" below:

MEDICOLEGAL SYMPOSIUM

Members of the medical and legal professions and of law enforcement agencies, and of other organizations interested in and concerned with the legal aspects of medical investigations of the causes of and responsibilities for deaths due to uncertain causes are cordially invited to a symposium dealing with the subject in the Page Auditorium of Duke University on Saturday, February 14, from nine to twelve-thirty. This symposium is being sponsored by the medical schools of Duke University and the University of North Carolina in cooperation with the North Carolina Society of Pathologists and the College of American Pathologists.

The speakers and the subjects they will discuss are as follows:

9:00 A.M.—THE FUNCTIONING OF A MEDICAL EXAMINER SYSTEM, ALAN R. MORITZ, M.D., Professor of Pathology and Director of the Institute of Pathology, Western Reserve University, Cleveland, Ohio, formerly Professor

of Legal Medicine, Harvard University, Pathologist to the Massachusetts Police Force, Boston, Massachusetts.

9:30 A.M.—UNEXPECTED DEATHS IN CHILDREN, RUSSELL S. FISHER, M.D., Chief Medical Examiner, State of Maryland, Baltimore, Maryland.

10:00 A.M.—TOXICOLOGIC ASPECTS OF MEDICOLEGAL INVESTIGATIONS RELATED ESPECIALLY TO ASPHYXIA, JAMES R. TEABEAUT, M.D., Chief of the Section of Legal Medicine, Armed Forces Institute of Pathology, Washington, D. C.

10:30 A.M.—BALLISTICS AND THE INTERPRETATION OF GUNSHOT WOUND EVIDENCE, CHARLES M. WILSON, M.D., Superintendent of the Wisconsin State Crime Laboratory, Madison, Wisconsin.

11:00 A.M.—QUESTION PERIOD, RECESS.

11:30 A.M.—SOME SURPRISING CONSEQUENCES OF INJURIES TO THE HEAD, A CLINICAL-PATHOLOGICAL CONFERENCE, WILEY D. FORBUS, M.D., Professor of Pathology, BARNES WOODHALL, M.D., Professor of Neurosurgery, GUY L. ODOM, M.D., Professor of Neurosurgery, Duke University School of Medicine, Durham, North Carolina.

Wiley D. Forbus, M.D.

Professor of Pathology, Duke University Chairman, Committee on the Coroner System, Medical Society of the State of North Carolina



President's Page



Fellow Members of the I.S.M.A.:

THE OFFICIALDOM of the Indiana State Medical Association will convene on Sunday, April 26, at the Hotel Claypool in Indianapolis. This will be the second interim session, perhaps better termed "bull session", staged by the House of Delegates. As you know, the House of Delegates furnishes the opportunity for your county representatives to speak on various issues with probity, because most of us—

"Honor the man who is ready to sink,
Half his present repute for the freedom to think;
And when he has thought, be his cause strong or weak,
Will sink t'other half for the freedom to speak,
Caring naught for what vengeance the mob has in store,
Let that mob be the upper ten thousand or lower".

When this is the attitude of each delegate, both sides of a question can be debated, compromised, and a definite policy proposed. However, the interim session of the I.S.M.A. lacks authority and can recommend only that the issues in question be referred to the annual session which is to be conducted at French Lick in October. The Constitution and By-Laws of the Indiana State Medical Association must be rewritten and the word "annual" deleted before recommendations of the interim session could be written into the Constitutional records. Therefore, why not abolish future interim sessions? A six-hour day presents insufficient time for rugged individualists to legislate important problems. Secondly, it is a waste of time, money, and energy to assemble busy practitioners in mid-year when these problems could be settled temporarily by the Council. The foregoing suggestions are mentioned for your consideration and study prior to the "to be about to be" interim session.

The idea of "sounding the death knell" for the interim session has been cogitated by several members of the official family. It harks back to the pervasive fact that physicians are obligated to attend too many medical meetings. Who can deny that organized medicine is over-loaded with meetings, conventions, and assemblies? As a member of a medical organization, a physician should plan attending at least part of the time, or cease to belong. For example, I am intimately acquainted with a physician who should go to 21 annual meetings, 11 national and regional, and 10 local. And this list does not include hospital staff or committee meetings of civic and lay-health organizations. With this sort of a schedule, when does one have time to do any research or organize clinical material for review or evaluation? When does one find time to register for a post-graduate course? Only those physicians in medical schools, hospitals, clinics, and group practice can attend regularly. Certainly, the physician in private practice is handicapped since he must leave his practice, which in turn permits the perennial attenders to speak for the majority. The killing schedules of

medical schools, which have youth for an alexipharmic, dwarf the demands made on the allopathic doctor if he heeds the oath of Hippocrates. Too often his vacations are planned in conjunction with conventions. The process of eliminating vacations and substituting conventions is a precursor of untimely coronary disease.

In 1953, 47 national medical meetings have been held or are to be arranged in the United States. This same year finds 38 international medical meetings which have been held or are being promoted in different countries. In addition to these you can add the number of meetings which are arranged by each state and county medical organization, let alone those planned by the specialty groups. And if organized medicine expects its members to increase their attendance, their qualifications, etc., a reappraisal, humane as well as scientific, of the demands on a physician by specialty, classification, standardization, and hospital boards, is in order.

One hesitates to make time-saving suggestions which might upset tradition because anything unconventional is often considered heretically or hieratically and seldom an honest effort to correct administrative inefficiency or to protect a physician's health. Most national meetings are becoming so cumbersome, especially in the way of satisfactory hotel accommodations, except in Atlantic City, Chicago, and San Francisco, that it might be a step in the right direction "to have and to hold" national conventions biennially. In the off year, regional meetings which are popular could be arranged, which would not conflict with the national meetings of other groups. It would be necessary also that the executive staffs of these organizations work out integral timing and locations for national, regional, and state meetings. This should not only increase the attendance but improve the quality of the subject matter which is presented. Meetings might be scheduled nationally so that similar groups, like the American College of Surgeons, Thoracic Surgeons, Urologists, and so on, could be visited in continuity. Interim or sectional meetings, if held in various parts of the country, would offer the physician who cannot find time to travel afar a chance to become enthusiastic about his organization, since he might attend a convention somewhat proximate to his emergency calls. After all, a rearrangement of time and place for all national, regional, and state medical conventions would give, at least, their respective executive staffs an opportunity to do a little home work.

Paul D. Grimm M.D.

P. S. " 'Tis better to remain silent and thought to be a d—— fool than to speak and remove all doubt." Some of you may think this applies to the preceding written dissertation.

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

FOR RESPONSIBLE TREATY MAKING

The irresponsible and frivolous manner in which treaties have been considered in the senate recently makes it imperative that action be taken to insure that no international instrument shall be ratified unless a senate majority passes upon it.

The Constitution provides that the President "shall have power by and with the advice and consent of the senate to make treaties, provided two-thirds of the senators present concur."

Mr. Frank E. Holman, past president of the American Bar association, has pointed out that within the year treaties and conventions have been approved with less than a quorum of the senate actually present. In January the mutual assistance treaties with Greece and Turkey were ratified with only six senators present. Not because the constitutionality of this procedure was called into question, but simply because the Greek and Turkish ambassadors felt insulted that no greater interest had been taken in the matter, the treaties were again called up, this time with a quorum present, and ratified all over again.

As we noted in an editorial of November 29, the treaty making process was rendered even more farcical last June 13, when two consular conventions and a protocol, involving Ireland and Britain, were ratified with but two senators present. Sen. Sparkman was presiding. The only other senator in attendance was Mr. Thye of Minnesota. Sparkman called up the conventions and protocol, cast the only vote on each, and then ruled that "in the opinion of the chair, two-thirds of the senators

present" had concurred and these instruments were duly ratified.

Sen. Thye said nothing during these proceedings. Later he conceded, "I did not object."

To our mind, as to Mr. Holman's, this is the height of irresponsibility. It shows with how little thought the country can be committed to grave and permanent international undertakings. Treaties of much greater importance could be railroaded through while most of the senate had its back turned. If these precedents are to stand unimpeached, the country may wake up some day to find itself committed to sweeping pledges to other countries by the vote of a handful of senators.

Of course, Sen. Sparkman could not have got away with this business if a single senator had risen to suggest the absence of a quorum. That would have forced a roll call and brought senators scurrying to the chamber until a sufficient number was present so that the pending business could be considered. If a quorum were lacking, the treaty, or convention, would have gone over until another day.

Perhaps the very carelessness of the senate in insisting on the point of order relating to a quorum dictates the need of a firm senate rule that a majority must be present whenever a treaty is to be brought up for vote. If the senators are to disown their responsibilities to the people, a way must be found to require them to discharge their duty on one of the most important matters with which the senate must deal.

—*Chicago Tribune*



Red Cross Aid to Troops in Korea

Since the beginning of the Korean conflict, 850 tons of supplies, at an estimated cost of more than \$485,000, have been shipped by your Red Cross to the troops in Korea. These supplies included 21,486,000 envelopes, 34,841,000 letterheads, 436,000 toothbrushes, as well as thousands of books, kit bags, combs, mirrors, razors, cards, pencils and other needed items.

PUBLIC RESPONSIBILITY IN CANCER CONTROL

Rollis S. Weesner*

Indianapolis

THE KEEN Frenchman, Alexis de Tocqueville, after traveling through the United States in the early part of the 19th century reported in his book on America—"Americans of all ages, all conditions and all dispositions, constantly form associations . . . to give entertainments, to found establishments for education, to build inns, to construct churches, to diffuse books, to send missionaries to the Antipodes, and in this manner they found hospitals, prisons and schools". He continues, "Nothing, in my opinion, is more deserving of attention than the intellectual and moral associations of America". Had de Tocqueville returned to our shores in the first half of the present century he would, no doubt, have added the field of health and welfare, in a big way, to the idea of voluntary action which impressed him so greatly more than a hundred years ago.

Cancer, and particularly the way it is being approached, is unique in this commendable field of voluntary action. Twenty years ago when people wrote to the American Cancer Society for information about cancer, 40 per cent asked that the answer come to them in a plain covered envelope. Last year, of the many thousands of requests for information, not one requested that a plain covered envelope be used in reply.

In a survey made in Pittsburgh in 1950 to determine the effectiveness of public cancer education it was found that 14 persons knew someone who had died of cancer to one who knew of someone cured of the disease, even though at that time approximately one out of four cures were occurring.

Among the many persons actively working in the various cancer society groups are many cured cancer patients. This is easily explainable, but why they continue to shield their experience and victory, when hopefulness is the strongest psychological weapon we possess, may not be

a mystery but it is, indeed, a challenge for greater educational effort.

Hopefulness springs from knowledge and confidence. The public must know something of the symptoms of cancer. It is a disease that cannot be diagnosed until after it occurs and "John Q." holds the key. He must present himself and his suspicions and he must have confidence in medical science and his physician's ability to do for him what is known and what is possible. In no other disease is the layman's burden of responsibility so large.

We know that an early cancer victim today has, at least, an even chance; yet only one in four wins. This is not the doctor's fault. The fault lies in ignorance, lethargy and medieval fear on the part of too many people. The history of control of other vicious and communicable diseases almost makes cancer a paradox because of the reduction of responsibility on the part of the individual in maintaining health and preserving life. A good example is typhoid fever, that once had to be the concern of every person but which now is the concern of only the sanitation experts and the health department. Even legislation has resulted in the practical control of some diseases. These things are mentioned to point up the fact that some past epidemiological diseases are now controlled by mechanisms for which the individual has no responsibility.—Not so cancer.

At the present stage of this fight we can say that modern science, more extensive and safer surgery and more penetrating radiation of various forms have made it possible to cure one-half of all cases: and yet we are not doing that. Why?—Because, chiefly the personal factor is involved. There is no mechanism to ward off cancer. There is no organizational or legislative means to round up cancer victims. But we can educate; we can make the individual apprehensive; we can give him knowledge and hope so that he can better understand and accept his individual responsibility toward this disease.

*Executive Director, American Cancer Society,
Indiana Division

Progress is being made, and in the words again of Alexis de Tocqueville "Nothing, in my opinion, is more deserving of attention than the intellectual and moral associations of America"—*sic*—who "by voluntary action do the thing that needs be done".

The formation of the American Cancer Society, its growth, influence and purpose manifest the acceptance of the great public responsibility in the effort to control cancer. Its greatest success to date, and its greatest obligation is *education*. Fundamental cancer research remains the bedrock of cancer progress, even though it is the hardest to evaluate. Optimism grows with each new discovery. The public, however, can only wait and hope and contribute his dollars to keep this work moving. Clinical research, on the other hand, is definitely adding today to the doctor's tools and to his confidence that cancer need not be a hopeless affliction.

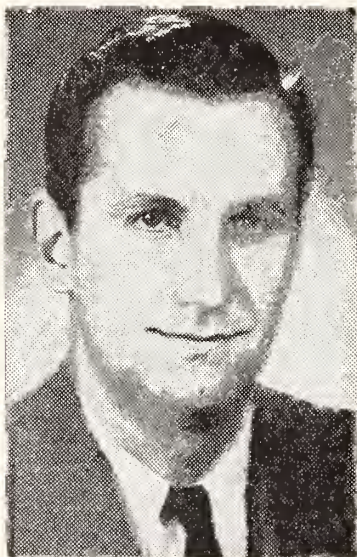
70,000 persons in this country will die of can-

cer this year who need not die. This will not be the fault of poor medical care. It will be because of lack of proper information relative to the symptoms of cancer; because of lassitude or fear of facts or economic strain. In other words, this quadrant of cancer mortality will not present themselves until it is too late to save them.

Indeed, there is a public responsibility which rests upon every individual in the control of cancer. The Cancer Society, by use of all known media for education and interest and arousing of apprehensiveness, is doing what it can to forearm an ever increasing and aging population to accept this responsibility. The doctor must be a part of this team. He must be an educator as well as a physician. Public responsibility means that every citizen share, and in this particular problem the advice and guidance of the physician can well be of greater value than his skill administered too late.

BRUCE G. NOWLIN JOINS I.S.M.A. STAFF AS FIELD REPRESENTATIVE

BRUCE G. NOWLIN, Lafayette, has been named Field Representative for the Indiana



State Medical Association. The appointment was effective March 1 and Mr. Nowlin has made several initial calls on county medical societies and individual doctors. He has been assigned to the northern section of the state.

Mr. Nowlin, who is a former resident of Indianapolis and graduate of Shortridge High school, has served as district manager of Blue Cross-Blue Shield in the Lafayette area for the last five years. His territory included ten counties.

During World War II the new field representative served for two years in the infantry. A major part of that time was spent in the European theatre of war.

Mr. Nowlin is married and has four children. He is 33 years old. He plans to retain his residence in Lafayette at 1918 North 16th Street and will travel throughout northern Indiana.

AMA DELEGATES APPROVE PRESIDENT'S PLAN FOR CREATION OF NEW DEPARTMENT

KARL R. RUDELL, M.D., *Indianapolis*

WASHINGTON, D. C., March 15, 1953 (Special)—All but four of the official delegates to the American Medical Association heard President Eisenhower extend the greetings of the administration and listened to his plea for assistance of the profession in bringing about a solution to the many complex health problems the administration faces. Gathered in the Ballroom of the Statler Hotel in Washington, D. C. on Saturday, March 14, the delegates heard not only the President of the United States, but also Senator Robert A. Taft and Congressman Walter Judd explain the president's proposal and subsequently approved the President's plan to create a Department of Health.

The following remarks were made by the President, after being introduced to a standing enthusiastic audience by Dr. Louis H. Bauer, president of the American Medical Association. "sometimes an individual finds himself in a position that he would like to explain even to himself. I certainly have no prescriptions to offer for anything that you people might be thinking about . . . And so, my appearance here is confined mainly to exercising my privilege of welcoming you, on behalf of the administration, in your deliberations in this city, and to express our great belief that the decisions you reach in the administrative field, particularly as they touch upon the functions of government, will represent your views of what is best for the United States of America, and not from any other viewpoint.

"Now, I have found, in the past few years, that I have certain philosophical bonds with the doctors. I don't like the word 'compulsory'. I am against the word 'socialized.' Everything about such words seems to me to be a step toward the thing that we are spending so many billions to prevent: that is, the overwhelming of this country by any force, power, or idea that leads us to forsake our traditional system of free enterprise.

"Now, that is the doctrine of the administration. It is most certainly the doctrine of the

Republican Party, and of Republican leaders in Congress. They are here to speak for themselves, but I am sure they will allow me that one word—and we live by it, and we intend to practice it.

"Now, we thoroughly understand, also, the importance of your functions in our society. We also understand, and are determined to meet the requirements of our population in the services that only you can provide. But we do have faith that Americans want to do the right thing, and the medical profession will provide better the kind of services our country needs, with the cooperation and the friendship of the administration, rather than its direction or any attempt on its part to be the big 'Pooh Bah' in this particular field.

"That is what I came to repeat. In many sections of the country, in every area, I have said these things before—and to some of you that are here today. I repeat them, and I tell you it is going to be the philosophy of this administration for the next four years, or as long as the good Lord allows me—all or part of it—to spend these four years.

"That is our pledge, and again, I express the confidence that you people will be helpful, according to your judgment of what is good for the United States of America.

"And now, let me repeat, on the part of the administration, a most hearty welcome.

"Actually, right now, I have something I can consult with you about. I have a sore wrist, and the problem is whether I can play golf or not this afternoon. But I am going to try it, I assure you.

"Good-bye and good luck."

President Eisenhower's words were taken as assurance that no plan such as that advocated by the Truman administration and labeled "socialized medicine" by the profession may be expected to come from his administration.

The President was followed by Senator Taft, who explained in detail the proposed new reorganization Plan No. 1 submitted to the Congress on March 12. The plan proposes to estab-

lish a Department of Health with the administrator or secretary having Cabinet status. The department will be broken down into three other departments covering Health, Education and Welfare, each having its own special assistant to the director. "This plan," said Taft, "should serve to provide a more efficient and uniform administration of this complex department and by providing the secretary with Cabinet status will serve as a balance against the department acting thoroughly independent of all other government operations as has been the case during the past few years." (The full text of the bill will be found in the pink section "Opinions from Here and There" as well as the full text of the resolution adopted by the House.)

Congressman Judd reminded the House that there are times, "when one must rise above principle" and in this case while the plan was not exactly what the profession had hoped for, nevertheless it represented a step in the right direction and was far more than the profession has received during the past 20 years.

Others who spoke in favor of the House approving the Plan were, Doctors Bauer, Henderson and Murray. Among reasons given for favorable action by the House on the reorganization plan were: 1. This is the first Plan to recognize medicine at the top level of a proposed department. 2. Organizationally it is an improvement over FSA in providing for medical programs. 3. It would give the Secretary greater authority in placing new people in policy making jobs.

It also was pointed out that under the present civil service system, the administration was burdened with those who were employed by and indoctrinated with the philosophies of the Truman administration. Top authorities in the FSA, many times found that policies, which were finally adopted, passed through 43 different hands before reaching them. In this manner, it was shown that those who were classified as the \$3 to \$5 thousand a year people were the makers of policy and not the top level administrator. These are the people who are

frozen in all departments of government through Civil Service, therefore it is necessary that the FSA be abolished, if the department is to be staffed with persons who believe in free enterprise rather than the doctrines many of them hold today. One of the first to go under the new plan will be Altmeyer whose job will be abolished.

In commenting on this particular problem Congressman Judd stated, "Thirty years ago the Civil Service system was instituted to protect the conscientious person who desired to make government service his career. But after 30 years it has failed. Those who we hoped it would protect have become frustrated and left for other employment, and today, we have only those who are forcing the government to work for their benefit."

While the Plan and its approval by the House does not represent the goals of the profession, the House went on record, which was later made unanimous, as approving the Plan but reserving the right, after a reasonable time to recommend a separate department of health if this program does not work out the way it is intended.

This special session of the House of Delegates marked the fourth time in the 106 year history of the Association that such a meeting has been called. A special joint session of the Senate and House Committee was called for Monday morning, March 16, for the purpose of speeding action on approval of the Plan. Congressman Brownson and Congresswoman Harden are members of this committee. The executive secretary has been invited to attend the hearing at which time official representatives of the AMA will testify before the committee urging immediate approval of the Plan.

The Indiana State Medical Association was represented at the Washington meeting by Delegates, Eli S. Jones, M.D., Hammond; Cleon A. Nafe, M.D., Indianapolis; Karl Ruddell, M.D., Indianapolis, and W. C. Stover, M.D., Boonville. The executive secretary accompanied the Delegates to Washington.

ARMY SURGEON GENERAL AUTHORIZES SERVICE-WIDE TESTS OF PLASMA SUBSTITUTE

The Army Medical Service has broadened its tests of dextran, a plasma substitute derived from sugar, to include all medical units in this country and oversea theaters, Major General George E. Armstrong, MC, the Surgeon General has announced. Army physicians have been authorized to requisition and use dextran wherever they believe it may be suitably employed in place of plasma.

Extensive trials of dextran in military and civilian hospitals in the United States and on combat casualties in Korea have shown that the polysaccharide plasma expander possesses many of the qualities of blood plasma and may eventually supplant plasma if present findings are confirmed.

General Armstrong emphasized, however, that the Army's requirements for whole blood, currently used in the ratio of three to one with plasma, would be undiminished by the substitution of dextran or serum albumin for plasma. Only whole blood, he said, contains the living red cells necessary to recovery of casualties who have lost more than 30 percent of their circulating blood volume.

Developed as a volume expander for the circulatory system by the Swedes during World War II, dextran is the product of the action of bacteria on ordinary cane sugar, molasses or beet juice. The original Swedish dextran, which accounted for a high percentage of allergic reactions in patients receiving it, has been considerably modified by American and British research scientists who now believe that dextran will cause fewer such reactions than plasma or blood itself.

General Armstrong reported that dextran appeared to be of greatest value in resuscitating patients in acute shock and in maintaining blood pressure in those undergoing major surgical operations.

An easily manufactured inorganic material,

dextran has the added advantage of being free of contamination by bacteria or viruses, including the virus of serum hepatitis which is frequently transmitted by blood plasma. Dextran costs about \$6.50 per 500-cc. bottle, compared to approximately \$27 for processing a unit of plasma.

Army medical authorities consider dextran or some comparable plasma substitute would be indispensable in a full-scale war, because supplies of whole blood and plasma would be inadequate for large numbers of military and civilian casualties. For this reason, they are desirous of testing dextran on the widest possible scale at this time, both to determine precisely its clinical effectiveness and to familiarize service doctors with its use.

The National Research Council has already recommended that dextran be stockpiled for use in case of emergency by the armed forces and the Federal Civil Defense Administration. The substance has also been approved by the Federal Food and Drug Administration.

The first trials of dextran among combat casualties were conducted last summer by a three-man Army medical research team headed by Colonel William H. Amspacher, MC, Director of the Army's Surgical Research Unit, and including Dr. Anthony R. Curreri of the University of Wisconsin Medical School, Consultant to the Surgeon General, and First Lieutenant Thomas M. Cloud, MC, a member of the Surgical Research Unit.

The team reported in July that dextran had been used with highly encouraging results on 61 combat casualties both alone and in combination with whole blood, plasma or serum albumin. More extensive front-line tests were begun in Korea late last fall. The results of this "user-trial," being conducted primarily at battalion aid stations and other forward medical facilities, will be available sometime in April.

WORKSHOP ON NURSING SUMMARIZED; RECOMMENDATIONS OUTLINED

"PROBLEMS of Nursing" was the general subject for discussion on December 4 and 5, 1952, at the Workshop on Nursing held in the State Board of Health Building in Indianapolis.

The meeting was under the supervision of the Committee on Improvement of Nursing in Indiana. Cooperating organizations were the Indiana State Nurses Association, the Indiana League for Nursing, the Indiana State Board of Nurses' Registration and Nursing Education, the Council for Hospital Licensure, the Indiana Hospital Association, and the Indiana State Medical Association. Staff members of the Indiana State Board of Health rendered assistance.

A report of the Workshop was published recently, giving a transcript of many of the talks. The problems discussed were detailed as follows:

1. How can Nursing Staff problems be presented to those in charge of Administration? (Problems are presented by the Nursing Staff to the Director of Nurses who promises to report to the Administrator. Nothing further is heard of the matter.)
2. Many professional nurses, especially the older ones, are confused about their place in the team concept. They do not know their relationship to the Licensed Practical Nurses, and other auxiliary workers.
3. Many members of the Nursing Staff, both professional and nonprofessional, do not know the extent of their responsibilities, since these may vary in different hospitals and sometimes even in the different divisions of the same hospital.
4. It seems that the problems of the functions of the Nursing personnel should be clarified. Should not the Administration with the co-operation of the Medical and Nursing Staff work out these functions?
5. Would it not be better to have the maids do some of the semi-nursing duties, rather

than have so many divisions of auxiliary workers?

6. How can student nurses learn more about bed-side nursing, that is, the fine points of skilled nursing, with the full program she now carries?
7. How can we teach leadership and the ability to direct other workers, to our students in the School of Nursing?
8. How can we change the attitude of some of our professional nurses, so that they will accept the Licensed Practical Nurse?
9. Can we teach our young graduate nurse the importance of continuing her education?
10. Some nurses are still using the excuse that they are "too busy" when confronted with poor nursing care service. Is it possible to get away from this attitude of emergency in nursing?
11. What is the Board member's place in the planning for better nursing education and better patient care?
12. What is the relationship of the Hospital Administrator to the Nursing Service Director? Should both be responsible for policies?
13. When nursing personnel is inadequate, should not the Medical Staff and the Board of Directors, as well as the Nursing Staff, take some of the responsibility in securing more nursing personnel? In other words, is it not a community responsibility?

Recommendations

That a committee, on the state level, made up of the representatives from the Medical Association, the Hospital Association and the Nursing Association, study and define the functions of the professional nurse and the other auxiliary workers. The report of this committee should be transmitted to local groups, with the same type of membership. They, in turn, should study the problems and report back to the state group, with any recommendations.

OFFICIAL CALL TO THE HOUSE OF DELEGATES INTERIM MEETING, APRIL 26

The interim meeting of the House of Delegates of the Indiana State Medical Association will be held on Sunday, April 26, 1953, at 10:00 a.m., at the Claypool Hotel, Indianapolis.

The House of Delegates will be constituted as follows: Marion County, eighteen delegates; Lake County, six delegates; Allen County, four delegates; Vanderburgh County, four delegates; Delaware-Blackford, three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Harrison-Crawford, Jasper-Newton, Jefferson-Switzerland, Madison, Owen-Monroe, Parke-Vermillion, Tippecanoe, Vigo and Wayne-Union County Societies, each two delegates; the other sixty county societies, each one delegate; thirteen councilors; and the ex-presidents, namely: C. S. Bond, W. H. Stemm, E. M. Shanklin, Charles N. Combs, George R. Daniels, Charles E. Gillespie, F. S. Crockett, J. H. Weinstein, R. L. Sensenich, Herman M. Baker, Karl R. Ruddell, M. A. Austin, Carl H. McCaskey, J. T. Oliphant, N. K. Forester, Floyd T. Romberger, Cleon A. Nafe, Augustus P. Hauss, C. S. Black, Alfred Ellison and J.

William Wright; and ex officio, the president, president-elect, executive secretary, and the treasurer of the association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the president shall cast the deciding vote.

The House will convene promptly at 10:00 a.m., in the Assembly Room on the eighth floor of the Claypool Hotel, and the meeting will continue through luncheon in the Chateau Room of the Claypool.

The order of business will be as follows:

1. Call to order by the president.
2. Roll call and seating of qualified delegates.
3. Reading of the minutes of previous meetings.
4. Appointment of reference committees.
5. Report of the treasurer.
6. Report of chairman of the Council.
7. Reports of standing and special committees.
8. Unfinished business.
9. New business.

JAMES A. WAGGENER,
Executive Secretary.

HOUSE OF DELEGATES INDIANA STATE MEDICAL ASSOCIATION *Interim Session* INDIANAPOLIS, INDIANA APRIL 26, 1953

County	Delegate	Alternate
ADAMS	James M. Burk, Decatur	
ALLEN	*H. Vaughn Scott, Fort Wayne	H. G. Haffner, Fort Wayne
	*W. C. Wright, Fort Wayne	R. H. Stauffer, Fort Wayne
	*Elmer C. Singer, Fort Wayne	Herbert M. Senseny, Fort Wayne
	*M. E. Glock, Fort Wayne	Gerald H. Somers, Fort Wayne
BARTHOLOMEW-BROWN	J. E. Dudding, Hope	L. F. Beggs, Columbus
	K. D. Schneider, Nashville	
BENTON	*V. L. Turley, Fowler	Charles Smith, Otterbein
BOONE	Clarence Kern, Lebanon	Alvin Schaaf, Jamestown
CARROLL	*Max Adams, Flora	Thomas C. Brown, Delphi
CASS	E. B. Jewell, Logansport	John Davis, Logansport
CLARK	H. H. Reeder, Jeffersonville	R. W. Bruner, Jeffersonville
CLAY	*John M. Palm, Brazil	Charles Moon, Center Point
CLINTON	*Frank Beardsley, Frankfort	Robert Hedgecock, Frankfort
DAVIESS-MARTIN	*Robert Rang, Washington	Arthur Blazey, Washington

County	Delegate	Alternate
DEARBORN-OHIO	*Gordon S. Fessler, Rising Sun *J. K. Jackson, Aurora	Charles N. Manley, Rising Sun M. J. McNeely, Dillsboro
DECATUR	J. T. Morrison, Greensburg	
DE KALB	R. A. Nason, Garrett	Charles I. Weirich, Butler
DELAWARE-BLACKFORD	Clay Ball, Muncie Kemper Venis, Muncie Edw. F. Wierzalis, Hartford City	
DUBOIS	G. A. Held, Jasper	John Bretz, Huntingburg
ELKHART	S. T. Miller, Elkhart Burton E. Kintner, Elkhart	J. W. Hannah, Wakarusa Floyd S. Martin, Goshen
FAYETTE-FRANKLIN	J. M. Lockhart, Connersville H. N. Smith, Brookville	Francis Mountain, Connersville Elmer Peters, Brookville
FLOYD	John M. Paris, New Albany	Harry E. Voyles, New Albany
FOUNTAIN-WARREN	Lee Maris, Attica James Crain, Williamsport	Lowell Stephens, Covington Carl Nelson, West Lebanon
FULTON	*A. E. Stinson, Rochester	John Glackman, Sr., Rochester
GIBSON	*Virgil McCarty, Princeton	H. G. Petitjean, Haubstadt
GRANT	Max Long, Marion	J. P. Powell, Marion
GREENE	J. A. Graf, Bloomfield	Carl Porter, Jasonville
HAMILTON	Sam Campbell, Noblesville	John S. Hash, Noblesville
HANCOCK	*J. L. Allen, Greenfield	R. E. Kinneman, Greenfield
HARRISON-CRAWFORD	W. E. Amy, Corydon	Carl Dillman, Corydon
HENDRICKS	O. T. Scamahorn, Pittsboro	J. C. Stafford, Plainfield
HENRY	*W. M. Stout, New Castle	L. C. Marshall, Mt. Summit
HOWARD	Richard P. Good, Kokomo	Robert Evans, Russiaville
HUNTINGTON	G. M. Nie, Huntington	T. W. Omstead, Huntington
JACKSON	Jack E. Shields, Brownstown	W. H. Shortridge, Seymour
JASPER-NEWTON	*W. G. Pippenger, Brook	
JAY		
JEFFERSON-SWITZERLAND	*Robert O. Zink, Madison L. H. Bear, Vevay D. W. Matthews, North Vernon Joseph F. Ferrara, Franklin H. O. Chattin, Vincennes Winton Thomas, Warsaw L. R. Studebaker, LaGrange Harry R. Stimson, Gary Ray Elledge, Hammond R. J. Modjeski, Hammond S. J. Petronella, East Chicago J. P. Birdzell, Crown Point J. P. Vye, Gary Victor F. Kling, Michigan City Donald M. Kerr, Bedford G. B. Wilder, Anderson P. T. Lamey, Anderson Ralph Everly, Indianapolis Floyd A. Boyer, Indianapolis James W. Denny, Indianapolis Wm. B. Lybrook, Indianapolis Bernard D. Rosenak, Indianapolis Howard W. Beaver, Indianapolis Lester D. Bibler, Indianapolis D. S. Megenhardt, Indianapolis Earl W. Mericle, Indianapolis Paul Merrell, Indianapolis K. E. Thornburg, Indianapolis Wm. M. Browning, Indianapolis R. A. Solomon, Indianapolis O. W. Sicks, Indianapolis Glen V. Ryan, Indianapolis John E. Owen, Indianapolis	S. A. Whitsitt, Madison Noel Graves, Vevay B. W. Thayer, North Vernon O. A. Province, Franklin V. C. McMahan, Vincennes George Schlemmer, Warsaw K. M. Lehman, Topeka Michael Shellhouse, Gary F. F. Premuda, Hammond O. L. Marks, East Chicago P. J. Rosenblum, Gary F. B. Monroe, Crown Point R. A. Elliott, Gary L. E. Benham, Bedford J. L. Doenges, Anderson R. R. Ploughe, Elwood Forrest L. Denny, Indianapolis O. H. Bakemeier, Indianapolis Edward F. Bloemker, Indianapolis W. Stanley Garner, Indianapolis J. E. Gillespie, Indianapolis Wm. G. Norman, Indianapolis Thomas A. Hanna, Indianapolis Paul K. Cullen, Indianapolis Don J. Wolfram, Indianapolis Wendell E. Brown, Indianapolis Philip B. Reed, Indianapolis Joseph E. Ball, Indianapolis I. J. Kwitny, Indianapolis George N. Love, Indianapolis Robert D. Pickett, Indianapolis Wayne Carson, Indianapolis
JENNINGS		
JOHNSON		
KNOX		
KOSCIUSKO		
LA GRANGE		
LAKE		
LA PORTE		
LAWRENCE		
MADISON		
MARION		

County	Delegate	Alternate
MARSHALL	Harry R. Kerr, Indianapolis	Clifford C. Taylor, Indianapolis
MIAMI	*A. A. Thompson, Tyner	M. O. Klingler, Plymouth
MONTGOMERY	D. W. Ferrara, Peru	
MORGAN	*J. M. Kirtley, Crawfordsville	F. N. Daugherty, Crawfordsville
NOBLE	R. W. Van Bokkelen, Mooresville	M. G. Murphy, Morgantown
ORANGE	J. R. Nash, Albion	B. H. Bulskamp, Wolcottville
OWEN-MONROE	Keith Hammond, Paoli	H. L. Miller, West Baden
	*Wm. C. Reed, Bloomington	R. E. Buckingham, Bloomington
	*Oran A. Kay, Spencer	C. E. Stouder, Gosport
PARKE-VERMILLION	J. R. Bloomer, Rockville	C. Harstad, Rockville
	Paul Casebeer, Clinton	F. J. Evans, Clinton
PERRY	Donald L. Lashley, Tell City	N. A. James, Tell City
PIKE	M. H. Omstead, Petersburg	J. L. Higgins, Petersburg
PORTER	Ralph C. Eades, Valparaiso	H. C. Ashmore, Hebron
POSEY	*Wm. B. Challman, Mt. Vernon	Paul Boren, Poseyville
PULASKI	*Wm. R. Thompson, Winamac	Charles A. Yale, Winamac
PUTNAM	Richard L. Veach, Bainbridge	V. Earle Wiseman, Greencastle
RANDOLPH	*R. M. Potter, Ridgeville	Arvin Henderson, Ridgeville
RIPLEY	Henry W. Conrad, Milan	L. H. Hopkins, Versailles
RUSH	Robert Johnson, Rushville	Davis W. Ellis, Rushville
ST. JOSEPH	*D. D. Stiver, South Bend	J. F. Murphy, South Bend
	*A. S. Giordano, South Bend	Donald Grillo, South Bend
	*	C. S. Culbertson, South Bend
	*F. R. N. Carter, South Bend	George Gates, South Bend
SCOTT	Marvin L. McClain, Scottsburg	Carl R. Bogardus, Austin
SHELBY	Paul Tindall, Shelbyville	W. D. Inlow, Shelbyville
SPENCER	*John Barrow, Dale	J. C. Glackman, Jr., Rockport
STARKE	Clark McClure, Knox	H. J. Henry, Knox
STEUBEN	Donald G. Mason, Angola	James A. Alford, Hamilton
SULLIVAN	C. F. Briggs, Sullivan	C. E. Whipps, Carlisle
TIPPECANOE	R. R. Calvert, Lafayette	W. W. Washburn, Lafayette
	Gordon A. Thomas, Lafayette	H. E. Klepinger, Lafayette
TIPTON	Albert Stouder, Kempton	S. M. Cotton, Goldsmith
VANDERBURGH	Minor Miller, Evansville	John E. Alexander, Evansville
	Henry Rusche, Evansville	Daniel C. Tweedall, Evansville
	E. L. Fitzsimmons, Evansville	Charles Schneider, Evansville
	C. C. Herzer, Evansville	L. Edward Gaul, Evansville
VIGO	Ernest O. Nay, Terre Haute	Wm. C. Kunkler, Terre Haute
	Hubert T. Goodman, Terre Haute	A. W. Cavins, Terre Haute
WABASH	George W. Seward, No. Manchester	O. G. Brubaker, North Manchester
WARRICK	W. C. Stover, Boonville	Bowen Hoover, Boonville
WASHINGTON	I. E. Huckleberry, Salem	A. R. Episcopo, Salem
WAYNE-UNION	Harry P. Ross, Richmond	Glen W. Lee, Richmond
	Will Thompson, Liberty	James F. Lewis, Liberty
WELLS	Truman Caylor, Bluffton	Hemer B. Annis, Bluffton
WHITE	*N. A. Hibner, Monticello	J. P. Galbreth, Burnettsville
WHITLEY		Otto F. C. Lehmberg, Columbia City

* Served in last House of Delegates. 1953 delegates not received.

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 3rd District—William H. Garner, New Albany
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 6th District—W. U. Kennedy, New Castle
 7th District—Roy A. Geider, Indianapolis

8th District—T. R. Hayes, Muncie, alternate

Councilor

9th District—Wemple Dodds, Crawfordsville
 10th District—J. R. Doty, Gary
 11th District—Elton R. Clarke, Kokomo, chairman
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 President-elect—W. Harry Howard, Hammond
 Treasurer—Roy V. Myers, Indianapolis
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 Executive Secretary—Jas. A. Waggener, Indianapolis

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 William H. Stemm, North Vernon
 E. M. Shanklin, Hammond
 Charles N. Combs, Terre Haute
 George R. Daniels, Marion
 Charles E. Gillespie, Seymour
 F. S. Crockett, Lafayette
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R. L. Sensenich, South Bend
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 Floyd T. Romberger, Lafayette
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 C. S. Black, Warren
 Alfred Ellison, South Bend
 J. William Wright, Sr., Indianapolis

DELEGATES TO AMA

Karl Ruddell, Indianapolis
 Wendell Stover, Boonville
 Cleon A. Nafe, Indianapolis
 E. S. Jones, Hammond

REFERENCE COMMITTEES—1953*Interim Meeting***1. Sections and Section Work:**

Minor Miller, Evansville (Vanderburgh),
 Chairman
 R. R. Calvert, Lafayette
 R. P. Good, Kokomo (Howard)
 D. D. Stiver, South Bend (St. Joseph)
 L. D. Bibler, Indianapolis (Marion)

2. Rules and Order of Business:

Ray Elledge, Hammond (Lake), Chairman
 N. A. Hibner, Monticello
 J. M. Kirtley, Crawfordsville (Montgomery)
 Paul Casebeer, Clinton (Parke-Vermillion)
 Robert Johnson, Rushville (Rush)

3. Medical Education and Hospitals:

Paul Tindall, Shelbyville (Shelby), Chairman
 D. G. Mason, Angola (Steuben)
 I. E. Huckleberry, Salem (Washington)
 V. F. Kling, Michigan City (LaPorte)
 J. W. Denny, Indianapolis (Marion)

4. Public Policy and Legislation:

Ralph Everly, Indianapolis (Marion), Chairman
 Paul Merrell, Indianapolis (Marion)
 E. L. Fitzsimmons, Evansville (Vanderburgh)
 Jack Shields, Brownstown (Jackson)
 Harry R. Stimson, Gary (Lake)

5. Publicity:

G. A. Thomas, Lafayette (Tippecanoe)
 J. William Wright, Indianapolis (Marion)
 Ralph C. Eades, Valparaiso (Porter)
 D. L. Lashley, Tell City (Perry)
 Harry P. Ross (chairman), Richmond (Wayne-Union)

6. Hygiene and Public Health:

O. T. Scamahorn, Pittsboro (Hendricks),
 Chairman
 J. L. Allen, Greenfield (Hancock)
 R. O. Zink, Madison (Jefferson-Switzerland)

D. W. Matthews, North Vernon (Jennings)
 Earl W. Mericle, Indianapolis (Marion)

7. Amendments to Constitution and By-Laws:

Joseph Ferrara, Franklin (Johnson), Chairman
 Clarence G. Kern, Lebanon (Boone)
 V. L. Turley, Fowler (Benton)
 J. K. Jackson, Aurora (Dearborn-Ohio)
 Winton Thomas, Warsaw (Kosciusko)

8. Reports of Officers:

Clay A. Ball, Muncie (Delaware-Blackford),
 Chairman
 J. M. Lockhart, Connersville (Fayette-Franklin)
 A. E. Stinson, Rochester (Fulton)
 Max Long, Marion (Grant)
 J. A. Graf, Bloomfield (Greene)

9. Committee on Credentials:

W. C. Stover, Boonville (Warrick)
 Truman E. Caylor, Bluffton (Wells)
 Albert Stouder, Kempton (Tipton)
 Clarke McClure, Knox (Starke)
 R. L. Veach, Bainbridge (Putnam)

10. Committee on Miscellaneous Business:

J. E. Dudding, Hope (Bartholomew-Brown),
 Chairman
 W. B. Challman, Mount Vernon (Posey)
 J. R. Nash, Albion (Noble)
 Donald W. Ferrara, Peru (Miami)
 G. M. Nie, Huntington (Huntington)

11. Committee on Prepaid Medical Insurance:

W. Harry Howard, Hammond (Lake), Chairman
 Frank Beardsley, Frankfort (Clinton)
 Robert Rang, Washington (Davies-Martin)
 J. M. Paris, New Albany (Floyd)
 William C. Reed, Bloomington (Owen-Monroe)

Deaths

Russell C. Wilson, M.D., 58, who had been a practicing physician in Franklin since 1926, died February 21 in his sleep. He had not been ill. Born in 1895 in Aurora, Doctor Wilson was graduated from Indiana University School of Medicine in 1926. He had previously served as a lieutenant in the United States Army during World War I. Doctor Wilson had served as Johnson County health officer for many years and held that post at the time of his death. He was active in civic affairs as well as those of his profession. A past president of Johnson County Medical Society. Doctor Wilson had been active in the promotion and development of Johnson County Memorial Hospital. He was a member of county, state and national medical organizations.

J. Edward Cullipher, M.D., 79, died February 20 in Mercy Hospital, Elwood, after a long illness. He had been in retirement for several years. A native of Madison County where he was born in 1873, Doctor Cullipher was graduated from the Medical College of Indiana in 1903. He established practice in Elwood in 1914 and had been prominent in medical, lodge and church groups in that community for many years. He was a member of Madison County Medical Society, a senior member of the Indiana State and American Medical Associations.

Horace E. Crockett, M.D., Indianapolis, died in St. Elizabeth Hospital, Lafayette, February 27. He had been seriously ill three weeks, however, ill health had forced his retirement five years ago. Born in Logansport in 1876, Doctor Crockett received his medical degree from Memphis Hospital Medical College in 1899 and had since practiced in Lafayette, Indianapolis and Chicago. Among his survivors is Dr. Frank S. Crockett, Lafayette physician, a brother.

Guy R. Coffin, M.D., Monticello physician for 45 years and former mayor of that city, died on March 5 in St. Elizabeth Hospital, Lafayette,

where he had been hospitalized for a month. Born in 1874 in Stilesville, Doctor Coffin taught school for several years before entering medical school. He was graduated in 1908 from Indiana University School of Medicine and established practice in Monticello that year. He served as a major in the medical corps during World War I.

Jesse E. Tucker, M.D., who practiced medicine in Elizaville for more than 50 years, died in Tippecanoe County March 10. He was 85 years old. Born in Henry County in 1870, Doctor Tucker received his medical degree from the Physio-Medical College of Indiana at Indianapolis in 1895. He was awarded a 50-year pin by the Indiana State Medical Association in 1947.

James M. Silvers, M.D., 80, Muncie, died February 18 in his home where he had been confined by an extended illness. A graduate of the Medical College of Indiana in 1904, Doctor Silvers practiced first in Jay County, then in Hartford City. He had been in Muncie since 1919. He had been a member for many years of the Delaware-Blackford County Medical Society, the Indiana State Medical Association and the American Medical Association.

Thomas B. Carpenter, M.D., Columbus, who was recalled to active duty in the U. S. Navy in November died March 7 of a cerebral hemorrhage at Barstow, California, where he was stationed at the Fifth Marine Depot. Born in 1921, Doctor Carpenter was a 1944 graduate of Indiana University School of Medicine. He was a specialist in obstetrics. Doctor Carpenter was serving as president of the Fourth District Medical Society.

The oldest practicing physician in Marion, **Lindley H. Eshleman, M.D.**, 82, died February 28 in Robert W. Long Hospital, Indianapolis, where he had been a patient for two months. A native of Pennsylvania where he was born in 1870, Doctor Eshleman completed his medical training at the Kentucky School of Medicine, Louisville, in 1896 after having taught school for

several years. Before 1900 Doctor Eshleman established practice in South Marion where he had been active until his final illness. He had served at one time as city health officer and was instrumental in securing enactment of the city's first milk ordinances. A veteran member of the Grant County Medical Society, Doctor Eshleman was a senior member of Indiana State Medical Association and an associate member of the American Medical Association.

William F. Waller, M.D., a native of Angola and practicing physician there for more than 30 years, died February 9 in Sacramento, California, where he had been ill for two years. Born in 1881, Doctor Waller was graduated in 1908 from Wayne University College of Medicine, Detroit, then established practice in Metz, where he remained until 1920 when he returned to Angola. A heart attack in 1948 forced Doctor Waller to retire. He had since been in Florida and California. He had been a member of the Steuben County Medical Society, the Indiana State and American Medical Associations for many years.

Frank G. Sink, M.D., 43, who had been in practice in Remington since 1937, died on March 10 in Tuscon, Arizona, where he had gone last October because of ill health. Born in Indianapolis in 1910, Doctor Sink was graduated in 1935 from the University of Arkansas School of Medicine following which he served his internship in Presbyterian Hospital, Denver, Colorado. Having established his practice in Remington, Doctor Sink returned there after serving for five years in the medical corps during World War II and had been active in that community until he became ill a year ago. A member of the Jasper-Newton County Medical Society, Doctor Sink had also been active in the Indiana State Medical Association having served as chairman of the Committee on Rural Medical Care in 1949 and as a member of the Committee on Civic Relationship and Community Health Agencies that same year. In 1950 he was chairman of the Committee on Rural Health and later a member of that committee. Doctor Sink was also a member of the American Medical Association.



The Indiana Academy of Ophthalmology and Otolaryngology will hold its annual meeting in Canyon Inn, McCormick's Creek State Park, Spencer, Indiana, May 6 and 7, 1953. Guest speakers will be A. N. Lemoine, Jr., M.D., University of Kansas, and Ben H. Senturia, M.D., St. Louis, Missouri.

All physicians practicing ophthalmology and otolaryngology are cordially invited to attend. For further information address: John R. Swan, M.D., 915 Hume-Mansur Bldg., Indianapolis 4.

News Notes

Annual Safety Conference, Exhibit of C. of C. April 15

Topic of the Indianapolis Chamber of Commerce's Annual Central Indiana Safety Conference and Exhibit will be "The Problems of Industrial Skin Diseases." The conference which has been arranged by The Alembert Winthrop Brayton Skin and Cancer Foundation of the Department of Dermato-Syphilology of Indianapolis General Hospital, will be held on Wednesday afternoon, April 15, from 1 to 3 p.m. in the Claypool hotel. Rex Joseph, M.D., and John Eric Dalton, M.D., are co-chairmen.

Moderator for the panel will be Leonard F. Weber, M.D., Chicago, clinical professor of dermatology, University of Illinois School of Medicine. Serving on the panel will be representatives of the following groups: Industrial Health Committee of the Indiana State Medical Association, Industrial Division of the Indiana State Board of Health, Indianapolis Claim Managers Council, Indianapolis Bar Association, Industrial Commission of the State of Indiana and a safety engineer.

The meeting is open and all physicians are invited to attend.

The Indiana Chapter of the **American College of Surgeons** will hold its first annual clinical meeting at Indianapolis on May 13. All members of the Indiana State Medical Association are invited to attend. Clinical sessions will be held at the I. U. School of Medicine beginning at 8:30 a.m. The complete program will be published in the May issue of *THE JOURNAL*.

On February 20, **Dr. Dan Urschel**, Mentone, addressed a combined meeting of the Northwestern Ohio Heart Association and the Toledo Academy of Medicine at the Academy Building in Toledo. The subject of his presentation was "Mean Spatial Vectorcardiography."

Dr. R. L. Sensenich Heads Cancer Campaign



Roscoe L. Sensenich, M.D., past president of the American Medical Association and the Indiana State Medical Association, is serving as chairman of the statewide fund raising drive of the Indiana division of the American Cancer Society. The annual campaign is now under way throughout the state, the fund raising drive being coordinated with an educational campaign during April, officially designated as Cancer Control month by an Act of Congress.

International College of Surgeons Section to Meet

Among the prominent speakers who will present papers at the annual meeting of the Indiana section of the International College of Surgeons on April 15 will be: Dr. Claude Beck, Western Reserve University, whose topic will be "Operations for Coronary-Artery Disease"; Dr. J. K. Berman, Indianapolis, "Surgical Aspects of Portal Hypertension"; Dr. Jack DeVault, United States State Department, Washington, D. C., "International Aspects of the International College of Surgeons"; Dr. Richard Appel, Indianapolis, "Causes and Treatment of Rectal Pain"; Dr. Myron Nourse, Indianapolis, "Surgical Treatment of Neoplasms of the Genitourinary Tract."

The all-day meeting will be held in the Indiana University School of Medicine auditorium with registration at 9 o'clock and the program beginning promptly at 10 a.m. The session will be concluded by 4 p.m. The meeting is open to all doctors, Dr. Thomas Cortese, secretary of the Indiana section, said in making the announcement.

Pendleton will have two new physicians in July when **Dr. Franklin K. Beeler**, Anderson, and **Dr. Morris Dickey**, New Castle, will open offices in that community. Doctor Beeler is interning at St. Elizabeth Hospital, Lafayette, and Doctor Dickey at General Hospital, Indianapolis. Both are graduates of Indiana University School of Medicine. Pendleton has had only one physician for some time and plans to bring the two young doctors there were made through the Chamber of Commerce committee headed by Dr. C. P. McLaughlin.

Dr. Albert J. Grant, who has been in practice in Monterey for the last year, has located in North Judson. Doctor Grant, a physician and surgeon, is a graduate of Jefferson Medical College, Philadelphia.

A Chicago doctor, **William B. King, M.D.**, has joined his brother, Dr. Robert King, in the practice of medicine in Cedar Lake. **Dr. Robert King** expects to be inducted into service in June.

Dr. Carl J. Brunoehler, who has been associated with the Moore-Hurley clinic at Muncie for several years, has opened a private office for the general practice of medicine and surgery in Hartford City.

Dr. Harry G. McKee, a native of Terre Haute and graduate of Northwestern University School of Medicine in 1949, has opened offices for the general practice of medicine in Rushville. He recently completed a term of military service, one year of which was spent in Austria.

The Ninth Annual Congress and Graduate Instructional Course in Allergy of the **American College of Allergists** will be held from April 24 through April 29 in the Conrad Hilton Hotel, Chicago. The instructional course has been scheduled for the first three days of the session and the Congress from April 26-29. Complete information may be obtained from the Secretary-Treasurer, The American College of Allergists, 401 LaSalle Medical Building, Minneapolis 2, Minnesota.

Fourth Supplement to Motion Picture Reviews Available

The Committee on Medical Motion Pictures of the AMA has completed the fourth supplement to the booklet entitled "Reviews of Medical Motion Pictures." It contains all the film reviews published in the AMA Journal from January to December, 1952.

The purpose of the reviews is to provide a brief description and evaluation of motion pictures which are available to the medical profession, each film reviewed by competent authority.

Copies are available to county medical societies on request from: Committee on Medical Motion Pictures, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

Dr. Marshall I. Hewitt, South Bend, has joined the professional promotion department of Parke, Davis & Company, Detroit where he will be engaged in the preparation and editing of medical literature and other material for the information of physicians. Doctor Hewitt had his general internship and residency in clinical research at Indianapolis General Hospital. Except for four years service as a medical officer with the U. S. Army in the Pacific and Japan during World War II, he had practiced internal medicine in South Bend before joining Parke-Davis.

Dr. Ernest H. Price, former practicing physician in Danville, is now associate radiologist at Memorial Hospital, Phoenix, Arizona, and is also associated with Dr. Douglas Gain in practice in Phoenix. Doctor Price was at the Indiana University School of Medicine and Veterans Hospital, Indianapolis, before going to Washington, D. C., last July for a course at the Armed Forces Institute of Pathology.

Medico-Military Symposium At Great Lakes in May

A combined Armed Forces Medico-Military Symposium for all Armed Forces of the United States will be held on May 6, 7 and 8 at the U. S. Naval Hospital, Great Lakes, Illinois. Advances in military medicine and the latest reserve plans and developments will be dis-

cussed. Attendance will give retirement point credit to all Reserve personnel who are not on the Inactive Status List. Many outstanding exhibits will be on display. For further information and complete program address District Medical Officer, Building No. 1, Great Lakes, Illinois.

Dr. Don G. Hilldrup, Indianapolis, who was in charge of a Red Cross mobile unit which visited Purdue University recently, reported that Purdue students set a state record by donating 375 pints of blood in a 6½ hour period and that the record may be a national one.

Dr. Alfred T. Chappel, who has just completed two years army service, has joined Drs. Oran A. and William D. Province in practice in Franklin. Doctor Chappel, a graduate of Indiana University School of Medicine, served his internship and partial residency at Henry Ford Hospital, Detroit, then entered the army for two years and was assigned to the cardiology section of Medical Service at the United States Army Hospital at Camp Atterbury.

Dr. John J. Hartman, who has been in military service at Camp Custer, Michigan, has returned to Angola and resumed his position on the staff of Elmhurst Hospital.

Dr. John C. Jones, LaPorte physician since 1947, has been recalled to active duty with the army medical services for a two-year period. He plans to return to LaPorte upon termination of his service with the army. In his absence, his practice and offices will be taken over by **Dr. Brian Potter**, plant physician at the Kingsbury Ordnance plant. Doctor Potter is a native of Manchester, England, graduate of McGill University School of Medicine, Montreal and served his internship at Royal Victoria Hospital, Montreal. He will continue in his capacity as Kingsbury plant physician.

The United States Civil Service Commission has announced a new **examination for medical officers** for filling positions in various specialized fields of medicine, with salaries ranging from \$5,940 to \$10,800 a year. Further

information and application forms may be obtained from the U. S. Civil Service Commission, Washington 25, D. C.

Congenital Cardiac Defects Booklet Being Distributed

A new handbook, "Diagnosis of Congenital Cardiac Defects in General Practice," is being distributed by the Indiana Heart Foundation and its affiliates. This handbook, designed for general practitioners and pediatricians, concerns the diagnosis of congenital cardiac defects and the management of patients with these defects.

It is written by Regina Gluck, M.D., assistant clinical professor of pediatrics, Children's Medical Service, Bellevue Hospital, New York. The booklet may be obtained from Indiana Heart Foundation, 1101 West 10th Street, Indianapolis.

Dr. E. Michael Truman, who has been in general practice in Rushville since July, 1950, has been called into active duty with the USAF, reporting April 1 to Lockbourne Air Force Hospital, Columbus, Ohio, where he was to be assigned to the obstetrical and gynecological service. Lt. Truman has been secretary-treasurer of Rush County Medical Society.

Dr. Herbert Kent, who has been at Veterans Administration Hospital, 1481 West 10th Street, Indianapolis, for the last three years, has been called to active duty with the United States Air Force and will leave the latter part of April for temporary assignment in Alabama before going to Sheppard Air Force Base, Texas. Doctor Kent, who has been chief of Physical Medicine and Rehabilitation at the VA hospital, was the guest speaker at a March 16 meeting of the Indiana Health Council in the Columbia Club, Indianapolis, discussing "Concepts of Physical Medicine and Rehabilitation."

Dr. Waldo J. Lehman, orthopedic surgeon, has joined his brother-in-law, Dr. R. L. Bender, in practice in Elkhart. A graduate of Northwestern University School of Medicine in 1942, Doctor Lehman served his internship and residency at Wesley Memorial Hospital, Chicago, then continued training at St. Mary's Hospital, Knoxville. He spent more than a year as a

plant medical director at Oak Ridge and most recently was chief of the department of orthopedic surgery at the Acuff clinic, Knoxville.

Lilly Grants Awarded Three at Purdue

Eli Lilly and Company, Indianapolis pharmaceutical manufacturer, announces that three grants have been approved recently to Purdue University.

One grant—to Dr. Henry Koffler, professor of bacteriology—will support his work on the intermediary metabolism of fungi.

A grant to Dr. C. L. Porter, professor of plant science, will support his investigation of antibiotics produced by certain micro-organisms.

A study on colorimetric applications of heteropoly complexes being conducted by Dr. M. G. Mellon, professor of analytical chemistry, is the subject of the third grant.

Dr. Jack DuMotte of the Neurological Institute of Kansas City spent a week recently at Norways private psychiatric hospital, Indianapolis making a detailed study of techniques and procedures.

Dr. Thomas O Middleton has reopened his office in Bloomington, having been released January 31 from service. Doctor Middleton served from July, 1943 to August, 1946 as flight surgeon with the 4th Air Force overseas. While in private practice as a pediatrician in Bloomington he was active in the Reserve Officers organization and when the 434th Troop Carrier Wing was reactivated May 1, 1951 he was recalled, serving first at Camp Atterbury and later Lawson field with the rank of major.

The American Goiter Association will hold its three-day 1953 meeting in the Drake Hotel, Chicago on May 7-9. All papers and

discussions will deal with goiter and diseases of the thyroid gland. Additional information may be obtained from Dr. George C. Shivers, 100 East St. Vrain Street, Colorado Springs, Colorado, corresponding secretary.

Indiana Trudeau Society To Meet On April 29

The 1953 Annual Meeting of the Indiana Trudeau Society will be held at the Lincoln Hotel, Indianapolis, on April 29. As usual it will take place the last day of the Annual Meeting of the Indiana Tuberculosis Association.

The morning Trudeau session on April 29 will feature a talk on "Pulmonary Function Studies" by Ralph C. Wilmore, M.D., Indianapolis, Assistant Professor of Medicine, Indiana University School of Medicine, and on "Treatment of the Unhospitalized Patient", by Herbert R. Edwards, M.D., Executive Director, New York Tuberculosis and Health Association.

During the afternoon, the Trudeau Society will hold a joint session with the Indiana Tuberculosis Association. This session will feature talks on "TB in Mental Institutions", by John V. Thompson, M.D., Indianapolis, Surgeon and Consultant, Indiana State Mental Institutions, and "Just Be Patient" by Herbert R. Edwards, M.D.

Other sessions of interest to physicians will be a talk by C. J. McIntyre, M.D., Indianapolis, on the morning of April 28, on "What the TB Patient Should Know", and the annual banquet of the Indiana Tuberculosis Association that evening, presided over by Wm. D. Province, M.D., Franklin. At this banquet the Auerbach Memorial Award for outstanding work in the TB field in Indiana will be given.

All sessions are open to any member of the medical profession in Indiana.

A.M.A. WASHINGTON OFFICE NEWS

Senate Committee Warned Against ILO. W. L. McGrath, speaking for the U. S. Chamber of Commerce, warns Congress that the International Labor Organization (ILO) has its sights set on enactment of socialistic laws, including socialized medicine, in each member country. Passage of the Bricker Resolution, he testified, would help forestall this. The measure has been before a Senate Judiciary subcommittee which still has to hear from Secretary of State Dulles and other administration officials. The resolution proposes to amend the Constitution so that treaties will not supersede federal or state laws and would require a federal law to carry out any treaty or executive agreement. Mr. McGrath represented the U. S. as an employer delegate at ILO meetings in Geneva. Philip B. Perlman, solicitor general of the U. S. from 1947 to 1952, testified against the resolution.

Medical Care Costs Slowing Down. According to latest report of U. S. Bureau of Labor Statistics (BLS), the rate of increase in medical care costs for the average urban family is slowing down. BLS first announced that during the last quarter of 1952 medical costs had risen 0.5% above the third quarter. However, BLS subsequently issued its monthly cost of living index which showed medical care costs for the 30-day period ending January 15 had risen only 0.1%. During the same period, rents and transportation costs went up 0.4%, gas and electricity 0.3% and other fuels 0.1%.

Commission Set Up to Study Taxes, Social Security. A bi-partisan commission of Congressional, federal and state officials has been authorized to make an extensive study, then recommend legislation on federal-state relations in the fields of taxes and health and social security. The commission, formed at the suggestion of President Eisenhower, is expected to complete its work within a year. Membership will include representatives named by the President plus others designated by Congress and by the State Governors' Conference. The commission idea was first advanced last November by Gen. Eisenhower and Senator Taft. (See Capitol Clinic, Vol. 3, No. 47).

The commission originated at a White House meeting February 26 attended by representatives of the governors, Congress and the executive branch. In a statement later, the President said the federal social security system warrants study. "This analysis should encompass not only the distribution of costs between the state and the federal government" he said, "but also the operation and coverage of the system itself. It is a proper function of government to help build a sturdy floor over the pit of personal disaster. . . However, we are equally committed to carrying out that great program efficiently and with greatest benefit to those whom it is designed to help."

Armed Forces to Reduce Call on Doctors, President Announces. After first planning to call up 1,800 physicians for April, May and June, the military services have decided they can get along with 1,200. Announcement of the lowered quota was made by President Eisenhower, who credited the reduction to recommendations of the Rusk Committee. The 1,200 to be taken in the next quarter compare with 1,552 called up in January, February and March.

Meanwhile, Defense Department's bill for extending the doctor draft act, made public two weeks ago, still has not been introduced on Capitol Hill. It is known that Office of Defense, Mobilization and the Budget Bureau are giving it careful study. Also, there are reports that White House advisers are hopeful that more reforms can be written into the bill.

Senators to Press for Early Action on Bricker Resolution. While prepared to hear both sides of the issue, Senators sponsoring the proposed amendment to the Constitution are anxious for early action on the measure, (S. J. Res. 1). The proposal calls for a constitutional amendment banning treaties and executive agreements that would abridge any domestic rights of American citizens. Chairman Langer of a Senate Judiciary subcommittee declared at the outset of hearings that "we want no delay." At this writing, a date for Secretary of State Dulles to testify hadn't been selected and there was no official word on what stand the Eisenhower administration would take. However, Senator Bricker (R., O.) who sponsors the resolution along with 63 other Senators, informed the Langer subcommittee he had talked with Mr. Dulles and other high government officials and that he had found "a common desire to work out something."

In his testimony before the subcommittee, Senator Bricker singled out the *International Labor Organization* as among the United Nations agencies working on treaties affecting American citizens. The Senator commented that ILO's "modest ambition is to become the economic overseer of all humanity." He said his bill would make humanitarian treaties subject to two conditions: (1) no such treaty could be effective if it would undermine constitutional rights of American citizens, and (2) no such treaty would be effective if it would entrust the rights of American citizens to supervision of international agencies over which they exercise no control.

Among organizations supporting the resolution are the American Medical Association and the American Bar Association (for AMA statement see Special Report No. 2, Feb. 18, 1953). Opposition witnesses include the Association of the Bar of the City of New York and B'nai B'rith. Opposition statements were filed by individuals and religious groups.

300,000 Inquiries Expected on OASI 'Waiver of Premium' Section. Testimony at a House hearing on a deficiency appropriation bill discloses that the Bureau of Old Age and Survivors Insurance is going ahead with preparations for putting into effect the "waiver of premium" section of the 1952 social security amendments. It would allow "waiver of premium" for persons covered by OASI, so their pensions at 65 wouldn't be reduced by their periods of permanent and total disability. The program was set up last year, but can't become operative and will expire next June 30, unless acted upon favorably by the current Congress. There has been no indication what attitude the new Congress and administration will take to the proposal.

The committee was told that this is the situation: 1. Carrying out what was interpreted to be the intention of Congress, the Bureau is developing policies and procedures to administer the disability program, preparing for possible congressional hearings, and exploring with states the best methods for coordinating federal and state functions. 2. Already 100,000 inquiries have been received, and the total is expected to reach 300,000.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

February 22, 1953

Roll call showed the following present: W. L. Portteus, M.D.; James W. Denny, M.D.; Paul D. Crimm, M.D.; E. R. Clarke, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump, attorney; James A. Waggener, executive secretary.

Guests: J. William Wright, M.D., and Harold Ochsner, M.D., co-chairmen, Legislative Committee; Lester D. Bibler, M.D., chairman, Subcommittee on Preceptorships.

By ballot, Dr. W. L. Portteus was elected chairman of the Executive Committee.

Membership Report

Number of members February 21, 1953 . . . 2,838*

Number of members February 28, 1952 . . . 3,020

Loss over last year 182

* Includes 107 in military service (gratis)

61—\$10.00 members (residents and interns)

181—senior members

1—honorary member

51—members, dues remitted by Council

Headquarters Office

Request of the Northern Tri-State Postgraduate Medical Association for permission to use the association mailing list calling attention to a meeting was approved on motion by Drs. Crimm and Denny.

Permission was granted the secretary to accept appointment on the Advisory Committee to the Division of Nursing Education of Indiana University.

Legislative Matters

Drs. Ochsner and Wright, co-chairmen of the Committee on Public Policy and Legislation, discussed legislative matters connected with the Indiana State Legislature and discussed in detail House Bills 421, 329 and 455, and Senate Bills 16 and 205.

Subscription to two copies of the *Washington Report on the Medical Sciences* at \$45.00 was approved by consent.

1953 Annual Session, French Lick,
October 19, 20 and 21, 1953

The secretary reported on the progress of the Scientific Work Committee.

1954 Annual Session at Fort Wayne

Letter was read from the management of the Allen County Memorial Coliseum, quoting a price

of \$3,600 for the three days if the association uses both floors. Upon motion of Drs. Denny and Crimm the Executive Committee referred this matter to the Council with the recommendation that the convention not be held in Fort Wayne due to the impractical arrangement and the cost.

Organization Matters

An ad in *The Indiana Publisher*, April issue, was approved on motion of Drs. Denny and Clarke.

Membership in the Indiana State Conference on Social Work at \$10.00 per year was approved upon motion of Drs. Clarke and Denny.

Requests of various county medical societies for remission of state dues of retired and ill members were approved on motion of Drs. Crimm and Clarke.

Dr. Lester D. Bibler, chairman of the Committee on Preceptorships, told of the meeting held jointly with the Rural Health Committee and the Committee on Medical Education and Hospitals and reviewed the policy adopted by these committees, and asked the Executive Committee to approve of this policy and to so inform the Medical School of their endorsement. This was approved upon motion of Drs. Clarke and Crimm.

The secretary reported on the organization of the Board of Trustees for the Indiana Medical Education Foundation, informing the committee that Dr. James W. Denny had been elected chairman and Dr. Lyman Meiks, secretary, and that the Fletcher Trust Company had been selected as the depository.

The secretary read the following statement to be used in answering a request of the Indiana High School Athletic Association on the matter of using oxygen in high school athletics, and the statement was approved by consent:

The question whether it is desirable to supply oxygen for athletes to inhale before, during, or after athletic contests, and whether it is advisable to lead athletes to count on oxygen inhalations to aid in recovery from extreme athletic efforts, has two aspects. One is the ethical, the other is the physiological.

Ethically, the idea is pernicious. If one contestant is to have oxygen, it becomes necessary in fairness to give it to all others, and one is back at the beginning with a great deal of expense and trouble added. If it is fair to give oxygen, why not caffeine, benzedrine, epinephrin, and a multitude of other chemicals? It is absurd to pretend that oxygen is a "natural" substance, for epinephrin occurs in the normal body too. The only logical and fair policy is to exclude all of these substances.

Physiologically, the idea is at once dangerous and futile. In any given maximal effort, an athlete's performance is limited by one or another of many possible factors. There is the output per minute of his heart, the capacity of his lungs, the efficiency of the transportation of oxygen by his blood, the efficiency of the transportation of carbon dioxide by his blood, the quality of his muscles, his general bony structure, his habits of posture and gait, and the skill with which he uses what he has. This is only the beginning of what must be a long list. Any one of these may be setting the limit to his performance, and all he knows is that some instinct is telling him he can do no more. It is unsafe to assume that lack of oxygen is the one limiting factor in all or even most situations. It is impossible to give oxygen without some inconvenience to the recipient, as everybody can testify after breathing through a face mask. To give oxygen to somebody who happens not to need it but is on the verge of collapse from excess of carbon dioxide, from difficulty in breathing, from dilation of his heart, or from any one of the long list of other possible causes, is to endanger his health and even his life. To lead him to rely on oxygen for recovery, or to stimulate him to carry on beyond otherwise safe limits, is also dangerous.

There are a few situations, such as the plunge for distance, where the lack of oxygen is sometimes the limiting factor, but even here other factors must often be at work. In any case, definite evidence that oxygen increases endurance, reduces evidence of effort, makes the athlete feel better, improves his performance, or hastens his recovery is lacking. In most situations the systematic administration of oxygen has negligible effects. The following is quoted from a careful report "Influence of Oxygen Administration on Cardiovascular Function During Exercise and Recovery", by A. T. Miller et al., in the *Journal of Applied Physiology* 5(4):168 (October) 1952:

"The influence of oxygen administration before, during and after exercise on heart rate, blood pressure, blood lactate, endurance and subjective impressions has been studied. The administration of oxygen before exercise was without effect on the magnitude of these changes during exercise and recovery. Similarly, recovery was not hastened by the administration of oxygen during the recovery period. When oxygen was given during the exercise, heart rate and blood pressure changes were not affected, but there was a small but significant decrease in maximal blood lactate concentration, and an increase in time required to produce exhaustion. It is concluded that inadequate oxygenation of blood in the lungs is of minor importance in determining capacity for exercise and rate of recovery from exercise."

It certainly would not do to deny an athlete whatever help oxygen may afford if he has collapsed after overexertion. But to encourage him to overexert, beyond the limits he has learned to respect from instinct and experience, in anticipation of the dubious aid of oxygen, for the sake of adding to the laurels of a team, school or coach is foolish, unfair and dangerous. Letter from Dr. Frank W. Messer was read.

Resolution from The Passaic County Medical Society (New Jersey) was noted.

A letter from the St. Paul Mercury Indemnity Company was read and continued pending receipt of additional information from this company.

The request of the Indiana Council on Children and Youth for \$100.00 to assist in developing scenic backgrounds for use on their television programs was approved on motion of Drs. Crimm and Denny.

The Journal

Report on advertising was approved by consent:

Total, February, 1952.....	\$2,143.61
Total, February, 1953.....	\$2,165.83

Future Meetings

Letter from the American Medical Association requesting Indiana to be represented at a meeting of the National Health Council, New York City, March 18 and 19, 1953, was read, and the secretary, in company of either Dr. Wright or Dr. Crimm, was instructed to attend.

A notice from the American Medical Association of a special meeting of the House of Delegates, called for March 14, 1953, at Washington, D. C., was read and the secretary was instructed to accompany the delegates and remain in Washington, making contacts, and then going on to New York.

An invitation of the Ohio State Medical Association, in which officers and any other members of the Indiana State Medical Association were invited to attend the annual meeting of the Ohio State Association on April 21, 22 and 23, 1953, was read.

A notice of special meeting to be held March 1 in Kansas City, Kansas, of the 14 midwestern states to discuss the nursing situation was read and the secretary was instructed to accompany Dr. Wright to this meeting.

New Business

Dr. Ramsey sought permission of the committee to publish a report of the recent nurses' workshop, held in Indianapolis, in which the association participated, and permission was granted.

A letter from the Pier and Fox Insurance Company of New York City was read in which they sought the opinion of the association on a disability plan being prepared for the American Medical Association to supplement local disability plans, and the matter was referred to Dr. Elton

Clarke for review and study, and the secretary was to contact the American Medical Association to determine if such arrangements were being contemplated at the national level.

The following names were recommended to the Blue Shield as possible members for the Board of Directors:

Hubert T. Goodman, M.D., Terre Haute, or
William C. Kunkler, M.D., Terre Haute;
Maurice V. Kahler, M.D., Indianapolis, or
Roy Geider, M.D., Indianapolis;
William L. Daves, M.D., Evansville.

The committee interviewed Mr. Bruce Nowlin, of Lafayette, for the position of field secretary for northern Indiana, and after a discussion the secretary was given permission to employ Mr. Nowlin March 1, 1953.

There being no further business the committee adjourned to meet again at 10:30 a. m., Sunday, March 29, 1953, in the Columbia Club, Indianapolis.

COMMITTEE ON PRECEPTORSHIPS

February 1, 1951

Present:

Committee Members: Lester D. Bibler, M.D., Indianapolis, chairman; Maurice V. Kahler, M.D., Indianapolis; Charles R. Alvey, M.D., Muncie; John D. VanNuys, M.D., Indianapolis; Joseph E. Dudding, M.D., Hope.

Guests: J. O. Ritchey, M.D., Indianapolis; Paul J. Fouts, M.D., Indianapolis; E. W. Shrigley, M.D., Indianapolis.

Committee members, W. L. Portteus, M.D., Franklin, and J. W. Denny, M.D., Indianapolis, were not present.

The meeting was opened by Dr. Lester Bibler who showed the purpose of the meeting as being to formulate recommendations concerning a preceptorship program in the Indiana University School of Medicine.

Dr. Maurice Kahler spoke for a short time on the program and its purpose as being an attempt to get the students out in the field and to inform them of the field of general practice. He presented a breakdown on a report appearing in the J. A. M. A.

Dr. VanNuys spoke of the program in other schools and he feels that more students would enter general practice if it were not for the Korean situation; however, they would not be well

enough trained in the procedures of general practice. He recommended the adoption of such a program.

Dr. Shrigley, a member of the Dean's Committee, presented a resumé of comments obtained by writing to ten medical schools that have such a program. Next he presented a partial result from a survey on the junior and senior class. The students were asked:

1. Would you be willing to undertake a preceptorship without financial assistance of any type? Yes—40.5%.
2. Would you be willing to undertake such a program with board and room furnished? Yes—47%.
3. No interest at all. 12.3%.

Phi Rho Sigma has had a preceptorship program for several years.

Dr. Ritchey spoke on the selection of preceptors and of general points concerning the plan.

The program has been discussed on two occasions by the council of the medical school and they have provided further investigation as an elective during the free quarter.

Recommendations of this committee are that a preceptorship type program be offered either during the junior or senior year. The preceptors shall be from the field of general practice. Selection of preceptors shall be by the Dean's Committee and assistance by the Indiana Academy of General Practice and a committee from the I. S. M. A. No financial remuneration is to be considered at the present time.

The state association should help publicize this program in that it is a good program, acceptable to the association.

A pilot plan should be conducted to work on the many problems of such a program. This pilot plan would of necessity be on a small basis during its early period.

A possibility of giving school credit for this period should be considered but must be approved by the council of the medical school.

A length of such a period of instruction should be no less than six weeks. The students should be screened, as well as the preceptors.

The committee recommends that the preceptor shall be an individual rather than a group and that the program shall not be limited to any given locale or size of community.

This plan will possibly be in effect during the summer quarter of 1953.

LOCAL SOCIETY REPORTS

Eight members of **Boone County Medical Society** met March 3 in Witham Memorial Hospital, Lebanon, where they heard a telephone seminar relayed from Indiana University Medical Center. The April meeting was scheduled for the first Tuesday at the same place. The February 10 meeting also featured a telephone seminar program and was held at 6:30 o'clock in Witham Hospital.

"Heart Disease" was the topic of the telephone seminar recording which featured the February 16 meeting of **Cass County Medical Society** in Memorial hospital, Logansport. Seventeen members were present.

The **Dubois County Medical Society** and its auxiliary held a joint dinner meeting February 12 in the American Legion home in Jasper. The 12 doctors attending held a business meeting following the dinner program naming their delegate and alternate to state convention and also 1953 committees. At the auxiliary meeting, election of officers was held and a vote taken to make a contribution to the Medical Education Foundation fund. A report of the doctors' immunization program, recently completed, showed that 163 smallpox vaccinations, 83 triple shots against whooping cough, diphtheria and tetanus and 156 booster shots against the same diseases had been given.

Homer Howes, M.D., Detroit, presented a paper on "How to Approach the Allergic Patient" before 45 members of the **Elkhart County Medical Society** at a 6:30 o'clock dinner meeting February 5 in the Hotel Elkhart. Applications of Dr. W. J. Lehman and Dr. Massaneri for membership were received and approval given for establishment of a Red Cross blood bank in Goshen. Announcement was made that the March 5 meeting of the society would be held in the same place with Dr. Mitchell Nechtow, member of the staff of the Norwegian-American Hospital in Chicago as the speaker.

His topic was to be "Practical Office Gynecology."

At the January 8 meeting of the Elkhart county group Dr. Arnold Jackson spoke on "Recent Trends in Thyroid Disease," new committees were named and Dr. K. E. Leasure was unanimously accepted as a new member.

Nine members of the **Fountain-Warren County Medical Society** met in Attica February 5 at which time they heard a paper on "Diseases of the Liver" given by Dr. Harold E. Bowman, Indianapolis. The March meeting was to be held in Veedersburg.

Members of the **Fulton County Medical Society** met March 6 in Rochester. Earle A. Miller, director of the Fulton County Welfare department, talked on the county medical plan and revisions suggested by the state welfare department. A committee composed of Drs. Dean K. Stinson, Howard Row and K. K. Kraning was appointed to work with the welfare department on the proposed changes.

John R. Brayton, M.D., Indianapolis, was the guest speaker at the February 10 dinner meeting of the **Hamilton County Medical Society**. Doctor Brayton discussed "The Present Day Treatment of Dermatological Problems."

A business meeting of the **Howard County Medical Society** was held on March 3 in the Francis Hotel, Kokomo. Twenty-two members attended.

Huntington County Medical Society members held their January, February and March meetings in the Moose Lodge home, Huntington, with attendance reported as 20, 19 and 14 respectively. Prof. Harold Smith, Purdue University, gave a report on "Rural Health in Indiana" at the January meeting; Dr. Charles Fisch, Indianapolis, spoke on "Modern Concepts in Treatment of Congestive Heart Disease" in

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Ulcer Facies Composite



February and Dr. Glen Irwin, Indianapolis, gave a paper at the March 3 meeting on "Anti-Thyroid Drugs and Radioactive Iodine in Treatment of Nodular Goiter and Diffuse Goiter."

One hundred percent attendance was reported at the **Johnson County Medical Society** meeting held in the Elks home, Shelbyville, on February 11. Two sessions, planned by the Indiana Academy of General Practice, were held at 3 and 8 p.m. Drs. Hansen and Best of the University of Louisville School of Medicine discussed "Angina," "Congestive Failure," "Catherization of the Heart" and "Cardiac Arrhythmias."

"Surgery in Infancy and Childhood" was the title of the paper presented by Dr. William L. Riker, Chicago at the February 19 dinner meeting of **LaPorte County Medical Society** held in the Spaulding Hotel, Michigan City. Twenty-six members attended. Discussion by the members followed on various aspects of VA care; ethics in connection with newspaper and radio relations and the possibility of acquiring a part time lay secretary.

A roundtable discussion of several topics of particular interest to members of **Lawrence County Medical Society** featured the February 4 meeting held in Dunn Memorial Hospital, Bedford. Subjects covered included city sewage problems, polio, Blue Cross and several compensation laws. Twelve members attended the noon meeting. Nineteen members of the society attended the March 11 meeting when the discussion was on insurance problems and on revision of the local welfare fees.

Montgomery County Medical Society's February 19 meeting was held in Culver Hospital, Crawfordsville, with 18 members in attendance. The scientific meeting was conducted by F. M. Blix, M.D., Ladoga, who read a paper on "Obesity." Dr. Jess E. Burks, Crawfordsville,

secretary-treasurer of the county society, has been recalled to service with the USAF. Doctor Blix was elected to succeed him.

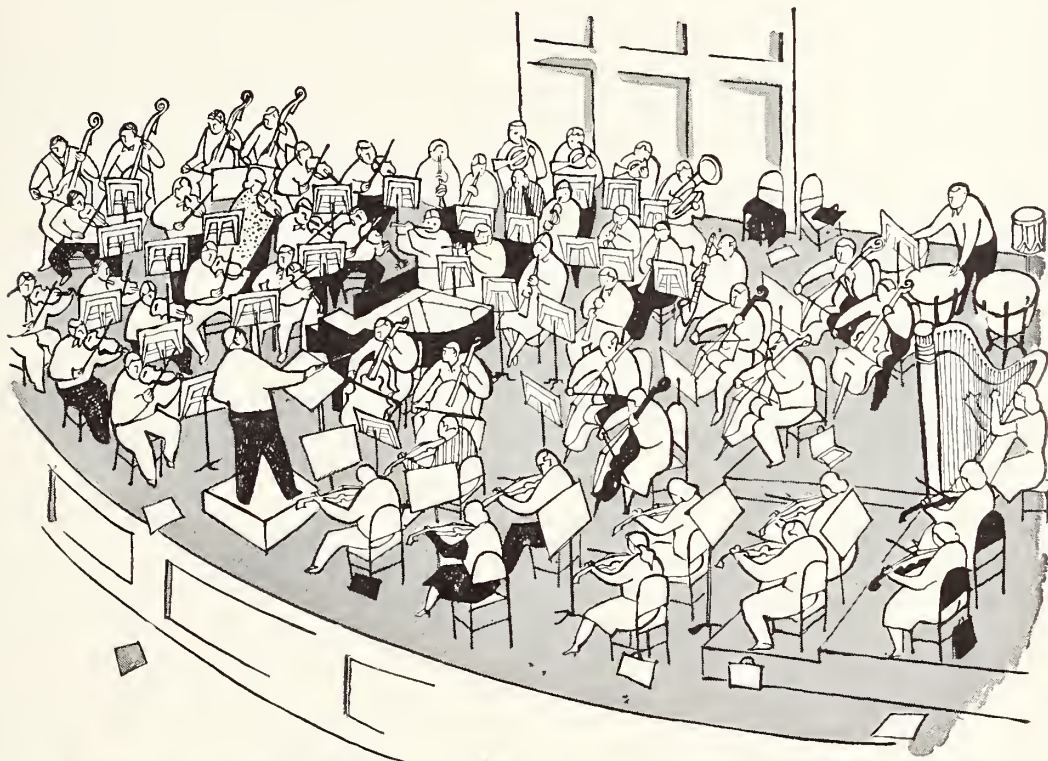
Fifteen members of **Parke-Vermillion County Medical Society** reached unanimous agreement on problems related to veterans care which were discussed at their February 18 meeting held in Vermillion County Hospital, Clinton. Date for the next meeting was set as March 18.

Dr. Bert Ellis, Indianapolis, discussed "Ear, Nose and Throat Problems Encountered by the General Practitioner" at the February 13 meeting of the **Putnam County Medical Society** held in the DePauw Memorial Union building. Sixteen members were present for the dinner meeting.

Bills introduced in the Indiana General Assembly which concerned the medical profession were discussed at the **Ripley County Medical Society** meeting on March 3. Robert Amick, field secretary for ISMA, led the discussion and later showed the films "Without Fear" and "Backfire." Five members and one guest, Bruce Nowlin, new ISMA field secretary for the northern part of the state, attended the meeting which was held in the office of the county public health nurse at Osgood. The next Ripley county society meeting was scheduled for April 7 in Sunman.

Fourteen members of **Shelby County Medical Society** met in the W. S. Major hospital, Shelbyville, for a 6:30 dinner meeting. A wire recording on "Thyroid Disease" was played and arrangements made for the pre-school roundup physical examinations and the free immunization program. The April 8 meeting was to be held in the Major Hospital.

The Indiana Heart Foundation sponsored the program February 12 of the **Steuben**



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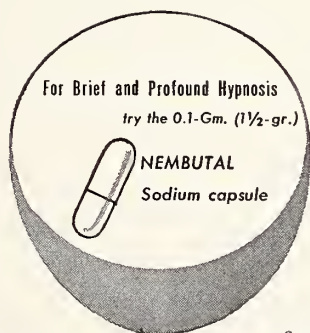
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County Medical Society which was held in Elmhurst Hospital, Angola. Following the dinner meeting a recording made at I. U. Medical Center on "Heart Diseases" was played.

Forty members of **Tippecanoe County Medical Society** held a social hour February 10 in the Fowler Hotel, Lafayette, followed by a dinner meeting in Lincoln Lodge. Featured speaker for the evening program was Leo Brown, publicity director of American Medical Association, Chicago, who spoke on "Affairs in Washington." He was introduced by Dr. F. S. Crockett. Special guests for the evening were Drs. Harold Ochsner and Cleon A. Nafe, Indianapolis, and James A. Waggener, executive secretary of ISMA. Doctor Ochsner gave a comprehensive report on bills which were under consideration by the State Legislature and additional remarks on that subject were made by Mr. Waggener. Announcement was made of a forthcoming Purdue University lecture of interest to the members, a request from Jefferson High School for a panel of doctors for a biology class program was referred to a committee and the problem of not being able to accept foreign interns and residents in Indiana hospitals was discussed by Dr. James M. McFadden.

Dr. William F. Meacham, Nashville, Tennessee, president of the Neurosurgical Society of America, was the guest speaker at the March 10 meeting of the **Vanderburgh County Medical Society** held at 6:30 p.m. in the Rose Room of Hotel McCurdy, Evansville. His subject was "Recent Advances in Intracranial Vascular Surgery."

Sixteen members of the **Wabash County Medical Society** met in the Honeywell Memorial center, Wabash, February 11 for a dinner meeting at which Dr. Charles Cooney, Fort Wayne, spoke on "Pathology of the Genitourinary Tract."

Election of officers was held at the January 22 noon luncheon meeting of the **Warrick**

County Medical Society in the Elks' club, Boonville. Three members attended.


Dr. Patrick Cummings read a paper on "Review of Two Cases of Reactivated Peptic Ulcers Following Orthopedic Surgery" at a meeting held February 10 in Washington County Memorial Hospital, Salem. Six members of the Washington County Medical Society were present for the evening meeting.


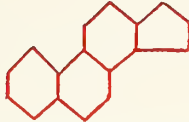

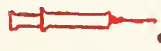



Plans for reorganization of **White County Medical Society** were made and officers then elected at a meeting held in Monticello on February 24. The next meeting was scheduled to be held April 14, the place to be announced.

Election of officers and the presentation of several interesting cases seen by the Genitourinary Services at Camp Atterbury highlighted the February 19 meeting of the **Camp Atterbury Medical Society**. Lieutenant Silbar and Captain Van Tassel presented the program. At the January meeting of the society the guest speaker was Captain Auerhan who presented a paper on "Three Cases of Peripheral Vascular Disease."

Dr. Maurice H. Fouracre, chairman of the United Cerebral Palsy Educational Board and head of the special education department of Columbia University, was the guest speaker for the February 10 meeting of the **Vigo County Medical Society** which was held in Union Hospital, Terre Haute. Doctor Fouracre is a national authority on education of handicapped children. Before accepting his present post, he was in charge of the department of special education for handicapped children at New York State College for Teachers in Buffalo.

Allen County Medical Society members held a dinner meeting in the Fort Wayne Chamber of Commerce on March 3. Forty-five doctors heard Dr. Mortimer Mann, Indianapolis, present a paper on "Vascular Diseases of the Eye." A labor-medical meeting was planned for April 7.

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Books

BOOKS REVIEWED

SIDE EFFECTS OF DRUGS. L. Meyler (Consulting Physician at Groningen, Netherlands). Translated by Ph. Vuijsje and M. Mulhall Corbet, Amsterdam. Elsevier Publishing Company, 402 Lovett Boulevard, Houston, Texas. October, 1952.

The author sets forth in the preface a sound philosophy for the use of drugs and points to the present-day misuse of drugs and the neglect of proper examination and deliberation by the physician. The book is well organized and consists of 25 chapters and 261 pages. The chapters are divided into titles indicating a class of drugs and in the case of each drug, or sometimes a group of drugs, there is a paragraph, the length of which is governed by the importance of the known side effects. At the end of each chapter is an extensive bibliography giving the name of the journal, volume number, year, and page, without titles of articles.

There is an extensive discussion of the side effects of antibiotics and sulphonamides.

The book is primarily a reference book and could be used as a textbook in connection with other works on pharmacology and therapeutics. It is the opinion of the reviewer that this book will become a valuable addition to the library of practicing physicians, teachers, and those engaged in chemotherapeutic research.

C. G. CULBERTSON, M.D.

NUTRITION AND DIET IN HEALTH AND DISEASE

by James S. McLester, M.D., Professor of Medicine Emeritus, University of Alabama, and William J. Darby, M.D., Ph.D., Professor of Biochemistry and Director of the Division of Nutrition, Vanderbilt University. Sixth Edition. Cloth, pp. 710. W. B. Saunders Company, Philadelphia, Pennsylvania. 1952.

This is the sixth edition of this book. Most of the first part on nutrition in health dealing with the need for food, its utilization, food products, and diet in health has been under the authorship in this edition of Dr. Darby, the new collaborator of the book. Dr. McLester has devoted himself to the second portion of the book in which the nutritional aspects of various diseases are discussed.

All chapters have been rewritten with emphasis on the newer factors in vitamins, amino acids and trace elements. Special regimens in the various diseases are thoroughly brought up to date especially in the treatment of hypertension, anemias, deficiency diseases, and diabetes. Most of the tables have been revised.

T. M. C.

INDIANA STATE BOARD OF HEALTH

Division of Communicable Disease Control

MONTHLY REPORT—JANUARY 1953

Disease	1953 Jan.	1952 Dec.	1952 Nov.	1952 Jan.	1951 Jan.
Animal Bites	111				
Chickenpox	805	413	516	489	367
Conjunctivitis	47	1	1	0	0
Diarrhea	9	3	4	12	9
Diphtheria	3	6	2	3	5
Encephalitis	1	2	2	3	0

Helmenthic Infestations	6	0	0	0	0
Impetigo	4	0	3	7	1
Infectious Hepatitis	69	48	40	24	4
Infectious					
Mononucleosis	10	0	0	0	0
Influenza	1856	52	145	67	51
Measles, German					
(Rubella)	24	17	10	31	8
Measles, Rubella	264	33	41	849	211
Meningitis,					
Meningococcic	8	5	4	2	5
Menningitis, Other	3	4	6	4	10
Mumps	190	93	93	537	167
Pediculosis	1	0	0	0	0
Pertussis (Whooping					
Cough)	61	32	30	86	89
Pharyngitis	1	0	0	0	0
Pneumonia	95	44	48	96	54
Poliomyelitis	9	23	120	3	5
Rheumatic Fever	1	2	0	1	1
Salmonella Infections	2	2	1	0	1
Scabies	2	0	0	0	2
Streptococcal Infections					
incl. Erysipelas, Scar-					
let Fever, Septic Sore					
Throat	414	213	173	190	178
Tinea Capitis	4	2	1	1	5
Tularemia	1	2	5	0	1
Typhoid Fever	1	0	3	2	2
Vincent's Infection	2	5	5	4	0
Virus Enteritis	1	0	0	0	0
Virus, Other	102	0	0	16	0

INDIANA STATE BOARD OF HEALTH

Division of Communicable Disease Control

MONTHLY REPORT—FEBRUARY 1953

Disease	Feb. 1953	Jan. 1953	Dec. 1952	Feb. 1952	Feb. 1951
Animal Bites	90	111	72	0	0
Blastomycosis	2	0	0	0	0
Brucellosis	1	0	0	1	1
Chickenpox	541	805	413	605	358
Conjunctivitis	47	47	3	2	1
Diarrhea, Infectious	1	9	3	12	0
Diphtheria	5	3	6	3	2
Dysentery,					
Bacillary	6	0	0	0	0
Unspecified	6	0	2	0	0
Encephalitis	1	1	2	2	2
Impetigo	17	4	0	2	1
Infectious Hepatitis	74	69	48	49	11
Infectious					
Mononucleosis	1	10	0	0	0
Influenza	5,220	1,856	52	1,105	64
Measles	138	112	50	951	624
Meningitis,					
Meningococcic	13	8	5	4	3
Other	1	3	4	10	7
Mumps	136	190	93	660	182
Pertussis					
(Whooping Cough)	33	61	32	34	97
Pneumonia	163	95	44	41	42
Poliomyelitis	8	9	23	6	4
Rheumatic Fever	6	1	2	0	5
Salmonella Infections	2	2	2	0	0
Scabies	3	2	0	0	0
Streptococcal Infections					
incl. Erysipelas, Scar-					
let Fever, Septic Sore					
Throat	408	414	213	423	234
Tinea Capitis	15	4	2	2	5
Vincent's Infection	6	2	5	4	0



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Books

BOOK REVIEW

OPERATING ROOM TECHNIC. 4th edition. Compiled by St. Mary's Hospital staff, Rochester, Minnesota. 345 pages with 219 figures. W. B. Saunders Company, West Washington Square, Philadelphia, Pa. Price \$6.50. 1952.

The fourth edition of this operating room manual was prepared for the surgical and nursing staff of St. Mary's Hospital of the Mayo Clinic. The introductory chapter of the book describes the surgical layout of St. Mary's Hospital with photographic details.

The setup for almost every operation is described; including a definition of the operation, position of the patient on the table, drapes, instruments, sutures and a brief outline of the surgical procedure.

As an Appendix there is a discussion of the Catholic doctrine regarding infant baptism.

The material of the manual is well prepared and it should be of interest to every surgery supervisor.

D. A. B.

PRACTICAL DERMATOLOGY FOR MEDICAL STUDENTS AND GENERAL PRACTITIONER by George M. Lewis, M.D., F. A. C. P., Professor of Clinical Medicine (Dermatology), Cornell University Medical College. Cloth. pp. 328 with 99 achromatic plates. W. B. Saunders Co., Philadelphia. 1952.

This book is an elementary guide in practical dermatology to be used by the non-dermatologist. As such it is designed as a text for medical students, a handbook for physicians in general practice and an aid in orientation for other specialists. It is well illustrated and presented in a concise, usable manner. Major clinical groups of skin disorders are briefly discussed and illustrated. Therapy is based on accurate diagnosis and an intelligent and integrated plan of attack. Chapter 24 is devoted to the various methods used in treatment of skin diseases. The next two chapters outline the dermatologic formulary and a cross index for quick reference as to drugs discussed. A general index concludes the book.

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8—	F. E. Keeling, Portland.....	Dec. 31, 1954
9—	Wemple Dodds, Crawfordsville.....	Dec. 31, 1955
10—	J. R. Doty, Gary.....	Dec. 31, 1953
11—	Elton R. Clarke (Chairman), Kokomo.....	Dec. 31, 1954
12—	M. B. Catlett, Fort Wayne.....	Dec. 31, 1955
13—	Kenneth L. Olson, South Bend.....	Dec. 31, 1953

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2.	Hugh S. Ramsey, M.D., Bloomington.....	J. S. Brown, M.D., Carlisle.....	Bloomington, May 14, 1953
3.	Joseph C. Dusard, M.D., Bedford.....	Eli Goodman, M.D., Charlestown.....	French Lick Springs Hotel, June 3, 1953
4.	T. D. Carpenter, M.D., Columbus.....	H. E. Rothring, M.D., Columbus.....	Columbus, May 6, 1953
5.	Gilbert D. Rhea, M.D., Greencastle.....	Stuart R. Coombs, M.D., Terre Haute.....	Brazil, May 13, 1953
6.	H. P. Ross, M.D., Richmond.....	John E. Fisher, M.D., New Castle.....	Connersville, April 30, 1953
7.	Ralph V. Everly, M.D., Indianapolis.....	T. V. Petronoff, M.D., Indianapolis.....	Indianapolis, May 27, 1953
8.	G. B. Wilder, M.D., Anderson.....	Warren Fisher, M.D., Anderson.....	Muncie, May 20, 1953
9.	Roland E. Miller, M.D., Lafayette.....	Hugh B. McAdams, M.D., Lafayette.....	Noblesville, May 27, 1953
10.	A. Lee Hickman, Hammond.....	Leo Cooper, Gary.....	Whiting, May 13, 1953
11.	Richard P. Good, Kokomo.....	C. R. Herd, M.D., Peru.....	Delphi, May 20, 1953
12.	Edward H. Schlegel, M.D., Fort Wayne.....	M. L. Habegger, Berne.....	Fort Wayne, May 21, 1953
13.	John E. Luzzader, New Carlisle.....	O. E. Wilson, M.D., Elkhart.....	South Bend, November 18, 1953

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Photographs should be printed on glossy paper. Negatives are not acceptable.

Only a limited number of illustrations can be used with each original article. If an excessive number are submitted for publication, the cost of extra illustrations must be borne by the author.

Contributors are responsible for all statements made in their articles. The editor and editorial board members may not be in agreement with various views expressed by authors, but it is desired to allow authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication only with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association. All communications regarding advertising and subscriptions should be sent to THE JOURNAL of the Indiana State Medical Association, 1017 Hume Mansur Building, Indianapolis 4, Indiana. Communications dealing with editorial matters should be sent to Frank B. Ramsey, M.D., Editor, 201 Hume Mansur Building, Indianapolis 4, Indiana.

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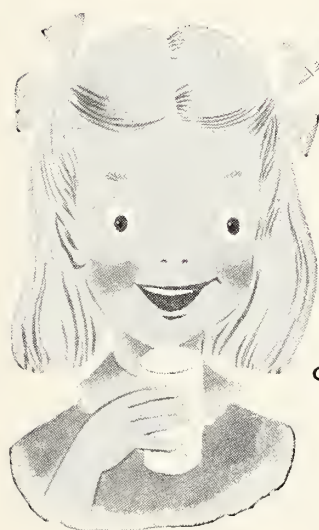
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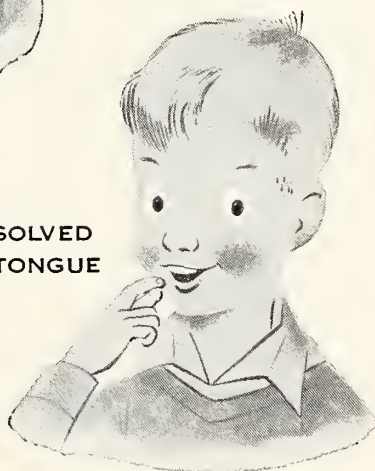


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Opinions From Here and There

Prepared for your information by the Committee on Public Policy and
Legislation of the Indiana State Medical Association

PHYSICIAN DRAFT TAKES 30 FROM INDIANA during month of April according to reports received by the headquarters office.

ESSENTIAL PROVISIONS OF DEFENSE DEPARTMENT'S BILL for amending and extending the physician draft were listed in the April 5 special report of the AMA Washington office. Hearing will be held looking forward to enactment prior to July 1. The AMA cautions that the provisions listed later are not criticisms of the bill, nor does it consider points that might have been mentioned in the bill but were not, such as extent of dependent care and the ratio of physicians to troops. It is a factual report of what does appear in the bill. It is suggested that a copy of the bill may be had by writing your Senator and requesting a copy of SB 1531.

NOTE: In all cases below reference is to "medical, dental and allied specialist categories" covered by the bill. Also, unless otherwise noted reference is to reserves as well as non-reserve special registrants, inasmuch as the bill groups them together with these words: "The President is authorized to order to active duty . . . members of the reserve components who . . . but for such membership would be liable for registration."

PRIORITIES. The existing four priorities would be retained. Most men in Priorities I & II (government-educated or World War II draft-deferred for educational purposes) already have served or are now in uniform. Remaining are Priority III (non-veterans) and Priority IV (those with service, if even for a day). Priority III men now are being called, with the youngest first. When Priority IV is reached, presumably those with the least service will be taken first, as suggested in present law.

REQUIRED LENGTH OF SERVICE (in the absence of a declaration *by Congress* of war or national emergency). The bill calls for a maximum 24 months' service with these exceptions: 1. Reservists and non-reservists who have served 12 months or more since June 25, 1950, could not again be called under the Doctor Draft Act. 2. *Reserves* who have served 12

months or more since September 16, 1940, but not in the period since June 25, 1950, could be required to serve no more than 17 additional months.

DEFINITION OF PRIOR 'ACTIVE DUTY.' For purposes of prior service credit, active duty is defined as time spent (a) on active duty or active duty for training in Army, Navy, Air Force, Marine Corps, Coast Guard, or U. S. Public Health Service, (b) on non-military duty prescribed for a conscientious objector, and (c) in the military service of a co-belligerent of the U. S. in World War II. Not accepted as active duty would be time spent in ASTP, V12, or similar training programs, or in "intern training, residency training, or other postgraduate training or in senior student programs prior to receipt of a professional degree."

LIBERALIZATION OF COMMISSIONING PROCEDURE. The bill attempts to assure that a man's *professional qualifications* shall determine his commission. The pertinent section states that any reservist on duty or ordered to duty "shall . . . be appointed . . . reappointed, or promoted to such grade or rank as may be commensurate with his professional education, experience, or ability." A Defense Department analysis of the bill adds: "This provision will insure that physicians, dentists, veterinarians, and allied specialist personnel will be given the rank to which they are entitled because of their professional qualifications without regard to whether they have previously served on active duty or have previously been commissioned as reserve officers." The bill specifically waives a section of the Armed Forces Reserve Act of 1952 which states: ". . . a person who has not held an appointment as a commissioned officer in any of the armed forces of the U. S. . . . may not be commissioned in a grade higher than major or lieutenant commander . . ."

TERMINATION OF RESERVE COMMISSIONS. Unless an officer had obligations for reserve service not originating in the Doctor Draft Act, his reserve commission would terminate automatically upon completion of his active duty. This provision would be retroactive to September 9, 1950.

NATIONAL ADVISORY COMMITTEE TO SELECTIVE SERVICE. The National Advisory Committee to Selective Service (Rusk) in conjunction with state and local affiliates would continue with present responsibilities, and in addition would be specifically authorized to "make determinations with respect to persons in residency training programs who shall be recommended for deferment . . . (and) with respect to members of the

faculties of medical, dental, and veterinary schools and schools of public health, having due regard to the respective needs of the Armed Forces and the Civilian population.”

OTHER PROVISIONS. Maximum induction age remains at 51 . . . Aliens otherwise qualified for service would not remain ineligible for commissioning solely because of their alien status or because they have not declared their intention of becoming citizens . . . Technically this proposal would amend the Doctor Draft Act, which is a part of the basic Selective Service Act. The bill would move up the expiration date for the Doctor Draft Act from July 1, 1953, to July 1, 1955, when the Selective Service Act itself is scheduled to expire.

AMA CONDUCTS SURVEY OF SEPARATED PHYSICIANS to determine the percentage of time spent by physicians in the treatment of military personnel and their dependents; staffing conditions, and the reasons given by physicians who have indicated they would be willing to serve beyond the period of 24 months. To make this determination 467 questionnaires were filled in by physicians separated from active military service since June 1, 1952, and included Army, Navy and Air Force physicians.

PERCENTAGE OF TIME SPENT IN TREATMENT OF THE FOLLOWING TYPES OF PATIENTS

	Military Personnel		Dependents of Service Personnel	
	Overseas	Domestic	Overseas	Domestic
Army	54%	53%	28%	26%
Navy	54%	46%	19%	25%
Air Force	44%	39%	19%	44%

STAFFING CONDITIONS ON LAST ASSIGNMENT

	OVERSTAFFED		UNDERSTAFFED		ADEQUATE	
	Number of Replies	Percentage	Number of Replies	Percentage	Number of Replies	Percentage
Army	16	15%	30	28%	63	58%
Navy	93	34%	40	15%	138	51%
Air Force ...	27	44%	9	15%	26	42%

WILLING TO STAY IN SERVICE

	YES	NO
Army	48	59
Navy	137	142
Air Force	29	35

BREAKDOWN OF REASONS GIVEN UNDER ABOVE ANSWERS WHEN ANSWER WAS "YES."

	ARMY	NAVY	AIR FORCE
In Case of Total War.....	5	6	1
If Higher Rank Available.....	1	1	—
Less Dependent Care	2	7	6
Better Utilization	1	7	1
Ability to Practice Specialty or Better Assignment	4	2	—
Better Rotation Policy	3	1	—
Miscellaneous Reasons	6	17	5
No Reason Given	26	96	16
	<hr/>	<hr/>	<hr/>
TOTAL	48	137	29

CLARIFY ADMIRAL BOONE'S STATEMENT. The AMA Secretary's Letter recently clarified a statement of Admiral Joel T. Boone the chief medical director of the Veterans Administration which had been reported in a previous letter as having said the following: "Admiral Boone stated there was not much difference between non-service and service connected disabilities." This was also the way his statement was quoted in THE JOURNAL of ISMA. The letter reports the record showed later that his testimony in this regard was as follows: "I am now in the position of seeing the backwash of war. I wish the critics would go through the hospitals with me and see what I see. I don't think there would be much debate about some of the little things related to service and non-service." The statement was made during the discussion of the question of Veteran Care at the Denver meeting of the AMA.

MALPRACTICE INSURANCE RATES UNDERGOING STUDY by both the Indiana State Medical Association and the AMA. Every effort is being made to obtain justification for the recent increases in rates or a lowering of the rates. You will receive an announcement from the Association on this in the very near future.

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CLINICAL EXPERIENCES WITH THE USE OF RADIOACTIVE IODINE IN THYROID DISEASE

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Indianapolis

DURING the past two and one-half years radioactive iodine has been used clinically at the Indiana University Medical Center. This agent has been found useful as a diagnostic aid in certain cases of thyroid disease, in the treatment of selected cases of hyperthyroidism and in the treatment of a limited number of cases of carcinoma of the thyroid. The handling of radioactive iodine requires special equipment, many precautions, and trained personnel. Our isotope laboratory has been under the direction of Dr. John Campbell. The safeguards for protection of patients, the operation of counting equipment, and the accurate measurement of radioactive iodine have required the specialized training of our radiophysicist, Mr. James Durlacher. This report is based upon a cooperative effort between the departments of radiology and medicine and

concerns our clinical experiences with the use of I_{131} , and a summary of the indications and limitations of this agent in clinical medicine.

I_{131} As A Diagnostic Aid

Radioactive iodine has been used primarily in two manners as a diagnostic aid in thyroid disease. Forty to 100 microcuries of I_{131} are given orally and 24 to 48 hours later the thyroid uptake of I_{131} is measured by a Geiger counter. Usually in the normal person, 10 to 40 percent of the dose is detected over the thyroid in 24 hours.¹ In addition the total 24 and 48 hour urinary excretion of I_{131} is determined. Both the I_{131} thyroïdal uptake and urinary excretion studies are done as a check on each other. Skanse² found that the total 48 hour urinary excretion of radioactive iodine varied in the normal from 44.0 to 87.8 percent of the total administered dose. Tables 1 and 2 summarize the uses and limitations of I_{131} as a diagnostic aid.

Presented at the Annual Session of the Indiana State Medical Association, on October 29, 1952.

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Table 1

I_{131} UPTAKE AND EXCRETION STUDIES MAY
BE ESPECIALLY USEFUL IN THE
FOLLOWING CONDITIONS:

1. Masked hyperthyroidism.
2. Severe hypertension which may or may not be associated with hyperthyroidism.
3. Psychoneurosis in which hyperthyroidism is questionable.
4. Detection of aberrant thyroid tissue (including metastatic carcinoma).
5. In evaluation prior to therapeutic I_{131} administration.
6. Thyrotoxicosis factitia.

Table 2

LIMITATIONS OF I_{131} UPTAKE AND
EXCRETION STUDIES

1. Results usually inaccurate if patient has received:
 - (a) Antithyroid drugs (propylthiouracil, tapazole, etc.)
 - (b) Iodine (Lugol's solution), cough mixtures, gall-bladder dyes, diodrast used for intravenous pyelograms and lipiodol.
 - (c) Potassium thiocyanate.
 - (d) Sulfonamides.
 - (e) Iodine deficient diet.
 - (f) Cortisone and ACTH.
 - (g) Desiccated thyroid.
2. Thyroid uptake of I_{131} depressed in many cases of renal insufficiency and congestive heart failure.
3. Accuracy limited in large nodular goiters.
4. Considerable overlapping of values between euthyroidism, hypothyroidism and hyperthyroidism.
5. Limited laboratory facilities and expense.

It is our experience that many patients with thyroid disease have received agents that limit the accuracy of I_{131} as a diagnostic aid. Radioactive iodine uptake is frequently low if a patient has received antithyroid compounds, iodine in its many forms, potassium thiocyanate, sulfonamides, cortisone, ACTH,³ or desiccated thyroid. In accurate diagnostic study these agents must be discontinued for usually a period of several weeks or several months. This is often not practical. This does not necessarily preclude the use of I_{131} as a therapeutic agent in less time than several weeks. Many patients with an iodine deficiency and goiter have a high uptake of I_{131} even though they are euthyroid.⁴ Our experience is similar to Keating and associates⁵ in that I_{131} thyroidal uptake may be de-

pressed significantly in some cases with renal insufficiency and congestive heart failure. We also agree with Werner and associates¹ concerning the inaccuracy of the test in certain cases with large nodular goiters.

Many claims have been made concerning the relative value of I_{131} diagnostic studies as compared to the value of the B.M.R. Table 2 lists the important limitations of I_{131} and, of course, there are many well known limitations to the B.M.R. There is little evidence that I_{131} diagnostic studies will supplant the B.M.R. in the study of thyroid disease. Radioactive iodine studies are recognized as an important aid in the difficult diagnostic cases such as listed in Table 1. Although there is now a variety of laboratory methods to determine thyroid function, it must be emphasized that good clinical judgment based on a careful history and physical examination remains the final basis for diagnosis of thyroid disease.

I_{131} in the Treatment of Hyperthyroidism

Radioactive iodine is an important agent in the treatment of selected cases of hyperthyroidism. There is considerable debate as to the relative value of I_{131} , surgery, and the antithyroid compounds in the treatment of goiter associated with hyperthyroidism. At the Indiana University Medical Center we have considered I_{131} as indicated and contraindicated in the thyroid conditions listed in Tables 3 and 4.

Table 3

INDICATIONS FOR TREATMENT OF
THYROID DISEASE WITH I_{131}

1. Recurrent diffuse goiter with hyperthyroidism following one or more subtotal thyroidectomies.
2. Diffuse goiter with hyperthyroidism in patients over 45 years of age.
3. Diffuse or nodular goiter with hyperthyroidism in which surgery is unsuited because of cardiac, pulmonary, or other complications.
4. Diffuse or nodular goiter with hyperthyroidism which fails to respond satisfactorily after adequate dosage with antithyroid drugs.
5. Hyperthyroidism which cannot be controlled because of patient sensitivity to antithyroid compounds.
6. Selected cases of nodular goiter with hyperthyroidism in elderly patients.
7. Selected cases of carcinoma of the thyroid.

Table 4

CONTRAINDICATIONS TO I_{131} THERAPY

1. Nodular goiter with hyperthyroidism (with a few exceptions).
2. Severe hyperthyroidism.
3. Congestive heart failure associated with hyperthyroidism.
4. Malignant exophthalmos.
5. Pregnancy associated with hyperthyroidism.
6. Patients under 45 years of age (with certain exceptions).

With a few exceptions listed in Table 3, it is our opinion that the treatment of choice for toxic nodular goiter includes the control of the hyperthyroidism with an antithyroid compound, the use of Lugol's solution for two weeks preoperatively followed by subtotal thyroidectomy. A nodular goiter does not have a uniform avidity for I_{131} and thus although the hyperthyroidism is controlled, the goiter with its nodule or nodules persists. It is believed that the subsequent occurrence of thyroid carcinoma or recurrent hyperthyroidism is more likely than following subtotal thyroidectomy. In addition thyroidectomy by competent surgeons has stood the long test of time.

Two cases in our series had a significant temporary increase in the severity of hyperthyroidism for about 10 days after the administration of I_{131} . For that reason we have used the antithyroid drugs to reduce the state of hyperthyroidism in patients with congestive heart failure and with severe hyperthyroidism. We have administered the I_{131} from 5 to 7 days after the antithyroid compound is discontinued. This precaution is recommended by Williams⁶ although Hamilton and Werner⁷ recommend the use of sodium iodide or tapazole for a short period following I_{131} administration if it is urgent to control the state of hyperthyroidism. The use of an antithyroid compound either before or after I_{131} may shorten the period of hyperthyroidism. It is established that I_{131} has a lag-period of two to four months before maximum effect is achieved. We have felt that antithyroid therapy before I_{131} administration to severe cases of hyperthyroidism would prevent the occurrence of thyroid crisis which has been reported following I_{131} treatment by Nelson and associates.⁸ Malignant exophthalmos has been reported to

occur and progress after I_{131} therapy.⁹ In pregnancy with hyperthyroidism it is the consensus that I_{131} is contraindicated because the fetal thyroid accumulates I_{131} after the third month and also because of the possibility of genetic changes. Many physicians believe I_{131} should not be used in patients under the age of 45 because of the possibility of late radiation carcinoma. This question at present cannot be answered absolutely in spite of the fact that no cases have been reported.¹⁰

Table 5 lists the untoward effects that may occur following I_{131} treatment.

Table 5

COMPLICATIONS FROM I_{131} THERAPY

1. Transient hypothyroidism.
2. Myxedema.
3. Acute thyroiditis.
4. Increase in hyperthyroid state which may result in:
 - (a) Congestive heart failure.
 - (b) Thyroid crisis.
5. Progressive malignant exophthalmos.
6. Possibility of late carcinogenesis (unanswered at present).

Thirty-five patients with hyperthyroidism have been treated with I_{131} at the Indiana University Medical Center. Six of these cases are not reported because sufficient time has not elapsed to judge effectiveness of treatment. Nine cases have been followed after I_{131} by the patients' personal physician and these cases are not included because at present our data is not complete.

Table 6 summarizes our experiences with I_{131} in the treatment of hyperthyroidism in 20 cases.

I_{131} in the Treatment of Carcinoma of the Thyroid

It must be emphasized that total thyroidectomy plus neck dissection in indicated cases, and x-ray radiation postoperatively remain the treatment of choice in carcinoma of the thyroid. I_{131} is useful in those cases with metastases which are inoperable and which accumulate significant I_{131} . Unfortunately, only a small percentage of metastases are functional and thus respond to I_{131} . Alveolar and follicular carcinoma are most likely to respond satisfactorily. Papillary carcinoma is less likely to respond and the highly undifferentiated carcinomas fail to respond to I_{131} . In some

TABLE 6
SUMMARY OF 20 CASES OF HYPERTHYROIDISM TREATED WITH I_{131}
AT THE INDIANA UNIVERSITY MEDICAL CENTER

<i>Type of Case</i>	<i>Number</i>	<i>Average Patient Dosage</i>	<i>Results</i>
I. Recurrent diffuse goiter following one or more thyroidectomies. 6		4.7 mec. (7 doses)	(a) Hyperthyroidism controlled in all cases. (b) Transient hypothyroidism in one case. (c) Myxedema permanent in one case.
II. Diffuse goiter in patients over 45 years of age. ----- 4		5.3 mec. (4 doses)	(a) Hyperthyroidism controlled in all cases. (b) Myxedema permanent in one case.
III. Nodular goiter in which surgery unsuited. ----- 5		9.4 mec. (7 doses)	(a) Hyperthyroidism controlled in all cases. (b) Hyperthyroidism temporarily increased in one case. (c) 4 of these 5 cases had recurrent nodular goiter in addition to their poor operative risk.
IV. Diffuse goiter in which hyperthyroidism failed to respond to adequate antithyroid drugs over a prolonged period of time. ---- 2		11.5 mec. (3 doses)	(a) Hyperthyroidism controlled in both cases. (b) Hyperthyroidism temporarily increased plus acute thyroiditis in one case.
V. Nodular goiter in elderly patients. ----- 1		8.5 mec. (2 doses)	(a) Patient controlled. Age 73 with arteriosclerotic heart disease and congestive heart failure.
VI. Miscellaneous group -----			(a) Hyperthyroidism not controlled. Repeated I_{131} not given because of increase in exophthalmos.
A. Diffuse goiter (age 32) ----- 1		5.0 mec. (1 dose)	
B. Substernal goiter (age 64) ----- 1		6.0 mec. (1 dose)	(a) Hyperthyroidism controlled. No tracheal compression.

instances the avidity for I_{131} by metastases may be increased by total thyroidectomy, use of thiouracil or tapazole, thyrotropic hormone, and "medical thyroidectomy" with I_{131} . Several investigators^{11, 12} believe that I_{131} is of little therapeutic value unless, after a test dose of I_{131} 30 percent or less is excreted in the urine in 48 hours.

One complication of I_{131} is bone marrow depression which is not listed in Table 5 but which may occur following large doses as used in the treatment of carcinoma.¹³

Since I_{131} has been used at the Indiana University Medical Center there have been no cases of alveolar or follicular carcinoma with metastases having significant I_{131} retention. Several of our treated cases were terminal and the follow-up period is short in several. We can only conclude that papillary and undifferentiated carcinoma of the thyroid have a poor I_{131} retention and have a poor response in general to I_{131} therapy.

Table 7 summarizes our experience with I_{131} and the treatment of carcinoma of the thyroid.

TABLE 7

CARCINOMA OF THE THYROID WITH METASTASES (10 CASES TREATED WITH I₁₃₁) AT THE INDIANA UNIVERSITY MEDICAL CENTER

Type of Carcinoma	Number	Thyroidectomy and X-ray	Significant I ₁₃₁ Uptake Urinary Excretion 30% or less	Results
Papillary Carcinoma	4	2	0	3 died (3 weeks to 1 year after treatment started) 1 living and well 16 months.
Carcinoma (Undifferentiated)	5	4	0	3 living (1 to 7 months) 2 died (3 weeks to 2 months after treatment started).
Carcinoma (clinical diagnosis only)	1	0	0	Died (4 weeks after treatment started).

SUMMARY: (1) 4 of the 10 cases are living 1 to 16 months after treatment started.

(2) To date, the two patients who lived the longest, both had papillary carcinoma, thyroidectomies, and the best I₁₃₁ retention of the group. (32% and 39% urinary excretion in 48 hours). One patient living and well 16 months and the other died 12 months after treatment was started.

Summary

Radioactive iodine has an established role in the diagnosis of thyroid disease, the treatment of hyperthyroidism, and the treatment of thyroid carcinoma. It is recognized that there is considerable controversy concerning the indications, contraindications and value for this agent. An attempt has been made in this paper to summarize the present day application of I₁₃₁ in clinical medicine.

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PROBLEMS AND DANGERS OF BLOOD TRANSFUSIONS

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THE RECENT history of medicine has been especially characterized by the rapid development and accelerated utilization of therapeutic procedures. The striking growth initiated in chemotherapeutic agents by Ehrlich, in antibiotics by Dubois and Fleming, and in plastic vascular surgery by Blalock, to name only a few, comprise a new resurgent era in medical science. If one may judge by present trends, the giving of whole blood by transfusion is about to be added to this list. It has recently been determined¹ in a university hospital in a large Midwestern city that the number of transfusions in the past nine years has increased nearly $2\frac{1}{2}$ times per bed and 2 times per patient. There can be no question that the proper use of blood transfusions has saved and will continue to save many lives and shorten hospital stay. On the other hand it is not entirely clear that the accelerated use of blood has been accompanied by a parallel increase in desirable therapeutic effects. Indeed, there is some reason to doubt that this may be true. In common with most forms of human activity the employment of therapeutic measures implies a variable risk. Progress in medicine has been due in no small measure to persistent critical analysis of means and methods to reduce this risk to a minimum. Stop and go lights are as essential on the busy streets of science as they are on our highways. It, therefore, appears appropriate at this time to point out some of the fallacies in the use of blood transfusions and some of the potential dangers in its use as well as means by which these hazards may be reduced.

Hemolytic Reactions

In spite of the obvious improvements in the handling of blood by the organization of blood

banks, incompatible transfusion reactions continue to occur even in the best organized hospital services. Some of these are due to the human error which probably cannot be reduced much further. Among these a common source of error results from improper methods of handling the blood after it has left the blood bank. The hospital should insist that the physician who is to administer the blood must personally go to the blood bank, the proper bottle obtained after checking with the blood bank technician and then carry it himself to the bedside to administer the transfusion. An attendant familiar with the signs of hemolytic reaction should be at the bedside of the recipient for at least 15 minutes after the blood has been started as during this period the manifestations of most fatal hemolytic reactions will become evident. The investigation of all hemolytic reactions as a standardized procedure is essential in order that the same mistake may not be made twice.

In contrast to the acute hemolytic reactions, slow hemolysis may occur under conditions unrelated to incompatibility of bloods. Laking of red cells may occur as the result of technical errors of collection and storage in which instance considerable hemolysis may be present in a flask of settled bank blood without discoloration of the supernatant plasma. Resuspension and resettling are necessary to show the color changes. In the presence of such hemolysis, a thorough investigation of the entire system of handling blood is mandatory.

In this connection, a word of caution against the use of over-age banked blood appears necessary. Reference to table I will show that banked blood, after five days of storage, suffers considerable loss through intravascular hemolysis during the first week after infusion. Following this period the loss levels off. The table shows that if blood is stored for two weeks, the immediate (5 minute) loss in red cells through intravascular hemolysis is 25 percent; in one

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TABLE I

BLOOD TRANSFUSION .
RED CELL SURVIVAL OF BANKED ACD-BLOOD

TimeIn Bank	5min.	7days	14days	21days
NO STORAGE	100%	75%	70%	65%
5 DAYS	95%	75%	70%	65%
14 DAYS	75%	55%	50%	45%
21 DAYS	70%	50%	45%	35%
24 DAYS	60%	55%	45%	40%

week approximately one-half disappears from the circulation.² This is probably due to the death or loss of viability of significant numbers of red cells during even relatively short periods of storage. Because the breaking up of the red cells is slow, no adverse effects upon the patient can be demonstrated. However, it is clear that if the blood is given to combat anemia, the storage period preferably should not exceed five days in the interests of conserving blood and time of personnel.

However, the most common cause of incompatible blood transfusion reaction is due to the ever increasing number of individuals who have been sensitized to antigens which can not be discovered by the routine matching and cross matching procedures. There are more than a dozen of the blood group antigens besides A, B and D (Rh) capable of sensitizing certain recipients. It can be mathematically shown that if both donor and recipient are properly matched and perfectly cross matched with respect to blood groups A, B and D at least 80% of the donations have one or more antigenic blood group substances that are introduced into the recipient.³ Fortunately actual sensitization does not occur in the indicated 80% of transfusions, because most of the introduced foreign antigens are weak. Table II lists the presently known blood group systems, the antigens capable of causing sensitization in the recipient and the frequency of transfusion reactions. When the blood is properly typed for Groups A, B and D, the table indicates that for every 500 transfusions that are given there will be approximately 1 incompatible blood transfusion reaction due to iso-antibodies that cannot

be detected by the presently employed routine matching and cross-matching. For example, in 23% of all transfusions Fy^a positive blood is given to Fy^a negative recipients. If this patient subsequently needs transfusion, there is a good mathematical chance that this patient will again receive Fy^a positive blood in which case an incompatible hemolytic blood transfusion reaction, probably fatal, will result. It is quite clear that as time goes on and blood is continued to be given in ever increasing quantities, the percentage of reactions of this general type will steadily climb. The risk is decreased if the donor and recipient are both Rh negative and greater if both are Rh positive. It should be remembered that transfusion risks are considerably increased if the donor is the husband of the recipient, because of the possibility of the development of erythroblastosis foetalis in subsequent pregnancies if sensitization occurs as result of the transfusion. Husbands should never be used as donors for their wives. It should also be remembered that certain patients are greater risks for the development of iso-immunization if they have one of the diseases belonging to the collagen group such as lupus erythematosus.⁴

Protection against the hazard of most incompatible reactions can be obtained by use of the Coomb's test in the cross matching. This is an effective safeguard against the administration of incompatible blood to a recipient who has been

TABLE II

BLOOD TRANSFUSION
BLOOD GROUP FACTORS †

SYSTEM	ANTIGENS CAUSING Tr. REACT.	FREQUENCY OF Tr. REACT. IF MATCHED FOR A-B & D.	% OF POPULATION c BLOOD ANTIGEN
ABO	A ₁ A ₂ B		41 10
Rh	C-c D E-e	0.23 0.18	85
MNS	M S-s	0.17 (s) 0.35	78 70 (s) 44
KELL	K-k (Cellano)	0.09	< 10
DUFFY	Fy ^a	0.23	65
KIDD	Jk ^a	0.18	77
P			70
LEWIS			95
LUTHERAN			10
LEVAY † *			RARE
Gr.(Graydon) *			RARE
JOBBINS *			RARE
MILTENBERGER ‡			RARE
JAY *			RARE

* PRIVATE BLOOD FACTORS
† POSSIBLE GENOTYPES 100,000,000
‡ POSSIBLE PHENOTYPES 600,000

sensitized by previous transfusion or pregnancy to one of these blood group factors. At the present time the use of Coomb's serum in the cross match is used routinely in only a very few hospitals. The importance of this type of reaction indicates that it probably should be used in all hospitals as part of the technique of cross matching procedure. The entire problem presented by iso-immunization is a most important one and the implications, both present and increasing in the future, are clearly apparent.

In any discussion of incompatible blood transfusion hemolytic reactions, the safety of the use of universal donors of Group O blood requires inspection. There is a mistaken feeling among many physicians that the use of Group O blood as a universal donor is a perfectly safe and acceptable routine procedure. However, there are at least two dangers in this procedure. First, is the danger of mistyping type A₂ donors as Group O. This can be eliminated by doing back typings, but these are not often done. The second and perhaps most important hazard results from the fact that some Group O persons have serum with unusually high titers of anti-A or anti-B or both. Under such circumstances, if this blood is given to a patient of Group A, Group B or Group A B, massive, although sometimes delayed hemolysis of the recipient cell, will occur. Since the hemolysis tends to be slow, fatalities from such hemolysis are not common. There is no satisfactory routine method for detecting the universal donor with high titer of anti-A or anti-B or both. If Group O blood needs to be stored for emergency purposes, it is recommended that 10 cc of 0.1% solution of A and B substances to each pint of Group O donor blood be added for any recipient other than that of Group O. In certain hospitals of limited resources where it is necessary to keep a pint or two of blood ready at all times for use in emergencies without preliminary typing, it is best that such blood be from Group O, Rh negative donor whose serum has been demonstrated to be free from anti-Rh antibodies or appreciable quantities of anti-A or anti-B.

Serum Hepatitis

Presently available evidence indicates that there are at least two viruses capable of producing hepatitis. The first has been identified primarily with the epidemiological and clinical syn-

drome of infectious or epidemic hepatitis. The other is associated with the parenteral introduction into the body of a virus by needle puncture or through plasma or blood transfusions or blood serum products. This is commonly referred to as homologous serum hepatitis. It should be remembered that both viruses can be transmitted by blood or its products and be responsible for hepatitis. The virus of infectious hepatitis when transmitted by blood, results in jaundice after a two to six week interval as compared to the jaundice following the introduction of the homologous serum virus which characteristically develops two to five months after the parenteral entry of the virus. It is, therefore, important to recognize that the hepatitis syndrome may be apparent as early as two weeks after receiving a transfusion containing the virus. Of further importance in the blood transfusion problem is the probable relative high incidence of non-icteric subclinical hepatitis in the general population, possibly as high as six percent.⁵ The problem is further complicated and made more hazardous by the fact that no practical clinical method for demonstrating the presence of hepatitis virus in the blood or its products has yet been developed and there is no practical procedure that will inactivate the virus that can be applied to blood or plasma without making them unfit for human use. Active immunization against virus of either infectious hepatitis or serum hepatitis has not yet been possible and human gamma globulin does not afford passive protection against the virus of serum hepatitis. Recent information indicates that the minimal incidence of hepatitis after blood and plasma transfusion is probably 0.6% to 0.8% of recipients receiving whole blood, about 1½% in small plasma pools, and 4½% to 12% in large plasma pools.⁶ These figures do not include the cases of hepatitis without jaundice. In other surveys the proportion of non-icteric hepatitis has been as high as three times the incidence of hepatitis with jaundice. Hence, the probable attack rate may be as high as one in every 50 transfusions. It is clear that the risk, especially from whole blood transfusions, is greatly increased by the frequent need for multiple transfusions into the same patient. It is true, of course, that everyone who receives transfusions of blood containing the virus will

not contract serum hepatitis. Probably an attack rate of approximately 40% is a good guess.⁷

The demonstration of the existence of asymptomatic blood carriers of the virus of infectious hepatitis is unquestionably of considerable significance in relation to the problem of blood transmitted hepatitis. In addition to the usual screening history and physical examination it is probable that all blood drawn before release should be tested quantitatively for total and prompt direct reacting serum bilirubin, 24 hour cephalin cholesterol flocculation test and thymol turbidity test, rejecting any blood that is positive by these screening laboratory measures. How much protection would be afforded by these laboratory procedures has not yet been adequately studied, but it is well known that physicians with clinical experience often are able to pick up unsuspected subclinical cases of infectious hepatitis by these or similar laboratory investigations.

Infectious Reactions

Infectious reactions, when they occur, carry an extremely high mortality. It is to be remembered that even properly refrigerated bank blood can serve as a culture media to many organisms that are normally found on the skin. This results from improper sterilization of equipment, improper preparation of the donor's skin, the introduction of room air into the transfusion flask at the time of phlebotomy or by improperly sealed bottles. These are almost always human error factors, and probably cannot be reduced much below the incidence that presently exists. Fortunately this is a very rare cause of transfusion reaction in the modern blood bank.

Speed Reactions

The so-called "speed reactions" are the result of circulatory overloading with resultant congestive failure of the right ventricular type. The chief clinical manifestation is the sudden onset of pulmonary edema and usually results in death. The signs of heart failure may not occur during transfusion or even for several hours after completing the transfusion. The causes are either too rapid administration of the blood or improper selection of patients for transfusion or in some incidences, both. It is a good rule to omit blood transfusions in those with diminished cardio-

vascular reserve unless the indications are extremely important. Under all circumstances slow administration of the blood is wise prophylaxis. Older patients or those with cardiovascular disease probably should not receive blood at a greater rate than one pint in 2½ hours. In this class of patients, if the object of transfusion is to overcome anemia, the safer procedure by far is to give packed red blood cells rather than whole blood. The practice often observed of giving more than one pint of whole blood per day in any patient except to combat shock or blood loss is thoroughly undesirable and in many patients is actually dangerous.

Gas Embolism

Gas embolism results from the introduction of air, oxygen, or other gases into the venous circulation occurring at the end of the blood transfusion when gas has been used to produce pressure in the transfusion flask. This method of accelerating the rate of transfusion material is to be condemned. If it is necessary to give blood transfusion rapidly because of co-existing rapid loss of blood, the procedure can be accomplished safely employing a three-way stopcock and a 50 cc syringe operated manually. The newer plastic bags containing liquid ACD which are now in experimental use as whole blood containers are promising as they contain no air and can be squeezed manually for more rapid transfusion than can be given by gravity. In most instances, however, pressure transfusions are unnecessary. Blood can be introduced rapidly enough in almost all cases if a large needle is inserted into the vein. A supply of 15 gauge needles usually makes the use of pressure methods unnecessary.

Benign Reactions

Anaphylactic and pyrogenic reactions are simply mentioned for the sake of completeness and to indicate that while they are unpleasant to all concerned, they are very rarely of any particular hazard to the patient. Most instances of anaphylactic reactions can be avoided by using resuspended washed red blood cells. This, of course, is only applicable when the need for giving transfusion is to overcome anemia. Pyrogenic reactions which sometimes seem to occur in a few patients every time they receive transfusions can usually be overcome by preliminary

preparation with 100 mgms of cortisone daily in divided doses beginning one day before starting the transfusions and continuing throughout the period in which the transfusions are administered.

Transfusion Therapy

The use of blood transfusions in hemolytic anemias requires clarification. The dangers involved in giving blood transfusions to patients with the congenital type of hemolytic anemia continues to be debated by hematologists. However, there are adequate published reports and personal experience to justify the statement that the giving of whole blood or resuspended red blood cells is hazardous in this disease. A certain portion of these patients will develop a fatal anuria due to the lower nephron syndrome. Entirely aside from the debatable aspects of this problem, it is completely clear that blood transfusions are unnecessary in this disease even when the red count has dropped to the 1,000,000 level. It is amazing how well patients with extremely low red counts will stand the procedure of splenectomy. There would appear to be no justification to give blood transfusions prior to the removal of the spleen in this disease. Any patient with congenital hemolytic anemia and a very low red count is a candidate for immediate and sometimes emergency splenectomy. Following the ligation of the splenic pedicle, blood can be given safely by transfusion if anxiety still persists as to the ability of the patient to survive the ordeal without the benefit of introduced blood. It is probable that experience with this disease at the University Hospital in Columbus, Ohio, has been as extensive as in any hematologic clinic in the world, and yet it has not yet been found necessary to transfuse any patient with congenital hemolytic anemia either before or after the removal of the spleen.

The danger of blood transfusion in the acquired types of hemolytic anemia is in somewhat different form. It is clearly hazardous to transfuse vigorously any patient with acquired hemolytic anemia if the rate of red cell destruction in the peripheral circulation is at a high rate. The repetitious transfusions serve only to eventually produce a fatal anuria. The proper procedure under these circumstances is to give one or two pints of blood in preparation for surgery withholding the remainder until after the splenic

pedicle has been ligated. The use of cortisone as a therapeutic measure in this variety of hemolytic anemia constitutes a valuable adjunct to splenectomy.

The problem of erythroblastosis foetalis presents a special problem in treatment. It has already been mentioned that the husband should not be allowed to serve as donor to his wife. The treatment for erythroblastosis is, of course, the transfusion of compatible blood which is Rh negative when the disease is due to iso-agglutinins of the Rh system. Unless the disease is very mild, it is important to treat this disease with the method of exchange transfusions. In the method of exchange transfusions more blood is removed than is put in which reduces the circulating blood volume simultaneously with the correction of the other abnormal factors. Not only does this procedure remove appreciable amounts of the iso-agglutinins and serum bilirubin which is responsible for the brain damage known as kernicterus, but also helps to relieve the congestive heart failure present in many infants that are very sick at birth.⁸ It should be remembered in this connection that erythroblastosis foetalis occurs not infrequently in the babies of women who are Rh positive. Under these circumstances the antigens A, B, E, c, and Kell are the usual implicated agents. This makes it essential to do proper blood tests in the infant with erythroblastosis foetalis before embarking on a program of treatment.

Repetitive transfusions in chronic anemia present special problems. The number of transfusions given to a patient increase the incidence of reactions, and hemolytic reactions correspondingly increase. This is probably due to sensitization to the blood groups other than those of the ABO and Rh systems. Transfusion of large quantities of blood also result in the development of hemosiderosis which has been held responsible by some observers for serious organic disease. Hemachromatosis has been described in many patients who have received large quantities of donor blood.⁹ Both these considerations make it advisable to give as little blood as possible for the maintenance of reasonable strength. It is our experience at the University Hospital in Columbus, Ohio, that individuals with chronic anemia develop surprising compensatory mechanisms which enable them to live satisfactorily with low hemoglobin. It is usually the part of wisdom not

to transfuse these individuals to levels higher than between 8 and 10 grams of hemoglobin per 100 cc of blood. An exception to this general rule prevails in patients with disabling cardiovascular disease. In this group of patients to promote maximum vascular efficiency it is well to keep them transfused to approximately normal levels, preferably with resuspended red blood cells rather than whole blood.

The use of whole blood by transfusion for the purposes of parenteral nutrition to maintain nitrogen balance or replace low serum proteins is ineffective, therefore, undesirable. The hypervolemic effect of whole blood makes it impossible to introduce enough serum protein to result in any appreciable correction of nitrogen balance for any sustained period of time or to raise appreciably the level of serum proteins. Additionally the risk of hemochromatosis is present. This type of problem should be handled by the infusion of amino acid solutions, serum albumin, or globin together with any possible dietary adjustment that one can make in a given circumstance.

Conclusion

The use of whole blood by transfusion is a rapidly growing and effective method of treatment in a wide variety of diseases for which no other satisfactory measure is available. However, with the accelerated interest in this method of therapy, larger and larger quantities of blood are being used without complete recognition of potential and growing hazards in the procedure. Over enthusiasm for this method of treatment has resulted in failure in some instances to properly balance prospective favorable therapeutic results against the potential hazards. The use of blood transfusions, unless indications are decisive, is to be discouraged. The use of so called "cosmetic" or "tonic" transfusions is a reprehensible practice. The practice of routine employment of blood transfusions pre-operatively, during the course of surgery, and post-operatively, apparently as prophylaxis against the development of shock also seems unwise. The combined hazards of transfusion probably far outweigh any value of such routine use of blood. Finally, the use of transfusions in the "physiologic" or spurious anemias (pregnancy, neurasthenia,

etc.¹⁰) constitute an additional fallacy in the use of this valuable therapeutic procedure.

Of particular importance over the prospective future is the potential risk of immunizing recipients to blood group antigens which cannot be recognized by the usual routine preparation for transfusion; thus rendering the patient liable, if sensitization occurs, to hemolytic reaction. This is of even more importance in women who may be sensitized to these antigens and are therefore liable to have erythroblastotic babies in subsequent pregnancies. It is pointed out that at least 80% of blood donations when properly matched with respect to the groups A, B, and D have one or more antigenic group substances that are lacking in the recipient cells and upon subsequent transfusions cross matched tests and the usual matching procedures do not demonstrate this type of incompatibility.

Additional risks of transfusions of blood include chiefly the possibility of transmitting serum hepatitis, or precipitating pulmonary edema in the patient with low cardiovascular reserve.

Suggestions have been given to serve as a guide for avoiding unnecessary transfusions and to minimize the dangers when transfusion becomes necessary.

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ROLES OF THE FAMILY PHYSICIAN AND LOCAL HEALTH OFFICER IN THE PUBLIC HEALTH PROGRAM

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LADIES and gentlemen, physicians, health officers and all well-wishers of the people of Indiana, let me thank you for the privilege of sharing in this meeting of your State Medical Association and particularly in this session of the newborn Section on Preventive Medicine and Public Health. As I look about me, I seem to feel the presence of that striking and very human figure in public health, the late Dr. John L. Hurty, who as state health officer made so noble a contribution to the well-being of the people of Indiana.

The title of this Section is auspicious, and comprehensive, yet precise and worthy of a well considered medical philosophy responsive to a rapidly increasing demand. The public and its servant, the medical profession, expect the broadest possible application of those medical sciences to which contemporary society owes so deep a debt as the chief cause of its material and cultural progress over the past hundred years.

So much of fame and praise is owing to many persons other than those of the professional brotherhood of medicine that we can speak proudly of the conquests of diseases in the past and confidently of the prospect of more triumphs in the future, and still maintain a proper and traditional humility as to the two great roles of the physician of today. He is in one capacity the indispensable and welcome personal and family

adviser in sickness and for health in the home, and in another, the officer of local government responsible for the application of authority of law and of public education to protect the community against preventable diseases and to raise the level of health by use of organized resources, official, voluntary, and professional.

If time and space had been fully conquered and you and I could have met at leisure to discover together the extent of our probable agreement as to the right and necessary roles of the family physician and the local health officer, I should have wished to read aloud to you one page of what I consider the soundest statement yet made in our language and addressed to us as physicians on the title of my present paper. I refer to the sixth page of the first chapter of the second edition of "Preventive Medicine and Public Health" by Dr. Wilson G. Smillie, Professor of Public Health and Preventive Medicine at Cornell University Medical College in New York.

This book has been prepared for medical students who are planning to practice clinical medicine and whose primary interest is in the diagnosis and treatment of disease, and yet it presents the whole philosophy and practice of modern public health.

I know no physician in private or public practice of the sciences and arts of preventive medicine, who is so well informed or so experienced, as to be able to disregard the facts, the principles and the implications of these for the future of medicine set forth so succinctly as they are to be found in this volume. The two fields we distinguish are medical care of the individual and public health protection for the community.

Presented at the Annual Session of the Indiana State Medical Association October 29, 1952 before the newly organized Section on Preventive Medicine and Public Health.

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What I mean by medical care is that entire range of applied science and the arts of medical practice included in the three words, diagnosis, treatment and prevention of disease—that is, medical science and art applied to the individual, who is sick, or fears he may be sick or wishes to preserve his health.

I know of no more comprehensive duty or privilege than that of the physician called upon by family or individual to bring relief from the presence or fear of pain, suffering or disability to a person or household that seeks his skill and sympathy and offers every useful aid and collaboration.

This constitutes the substance of medical care. All skills and resources commanded by the physician are focused upon the one and unique person, his patient.

The essence of medical care, as we have for a long time thought of it and carried it on in this country, is its uniqueness, the personal quality of the need or demand for care and the individual characteristics of the physician concentrated upon the one and only problem of instant importance, namely, the better or continued health of a patient.

It seems to me improbable that any substitute for such personal medical care can be developed through the mechanism of civil or military government by the compulsion of laws, or in the presumed interest of economies or uniformity of distribution.

What do we mean and intend by the term, the functions, the practice of public health? As Dr. Smillie says, "Public health encompasses those activities that are undertaken for the prevention of disease and the promotion of health which are primarily a community responsibility". The local health officer is the authorized representative of civil government, responsible for making effective use of the sciences of preventive medicine for the benefit of the community he serves. He has two resources, the authority of sanitary laws, ordinances, rules and regulations, and the persistent persuasive force of popular or mass information, so called popular health education.

If we accept, as I believe we must if we are to survive as free people, that government should do only such services as the people can not do as well, or at all, in their individual capacities, then it must appear that the local health depart-

ment has a well defined sphere. Who else but the local health officer and his staff can be trusted to carry out the six essential or basic services of health statistics, (birth, death, and disease records,) preventable disease control, environmental sanitation, public health laboratory work, protection of maternity, infancy, and childhood, and keeping the public informed as to the facts of human biology that bear upon health, survival, longevity, and right living?

If you analyse critically the local health services now carried on under some 1,200 full time medical officers of health and serving about 72 percent or 109,000,000 of our people, you will be at a loss to find anything being done by the local health departments of rural or urban communities, which any other agency or group or profession could do as competently and with so little interference with the traditional and useful relations between family and family physician. In the discussion of my paper I hope you will challenge this statement and reveal instances of function improperly served by local health departments.

Suffice it to remind you that each of the half dozen principal duties of a local health department has been so long and so widely tested as to usefulness, methods, costs and results that there can be no controversy as to their proper place among the functions of any jurisdiction of local government that presumes to represent voters and taxpayers. These basic functions have been included within the scope of local government for a scant hundred years, while the sphere of the physician in medical care has been broadly comprehensive and consistent in its expansion for more than a thousand years.

Here and there in several states and in about 6 percent of local health jurisdictions, the community has charged the local health department and its officer with other functions, some preventive and some for care of the sick. Each community has the right to determine the use of its own tax money for public purposes. Where medical care of dependent persons has not been otherwise provided for and the health department is commissioned as in Maryland and the State of Washington to administer this service, rather than some other agency of the community, this need not be a cause of intra-professional controversy.

If, then, the health department serves the community in the mass prevention of disease in ways not otherwise so effectively carried out, what do we mean by *preventive medicine* and who is responsible for its effective use? Preventive medicine is a primary factor in the services of the personal and family health adviser and is inseparable from the practice of so called curative medicine. Diagnosis is first to discover any functional or structural abnormality and then to treat the cause and the symptoms. But before disease or fear of it have annoyed the patient, the physician may detect early preventable stages of unsuspected or silent disease.

The distinction between preventive medicine as a dominant duty of the physician (as for example in pediatric practice) and public health, is that the former is first an individual responsibility carried on for and within the family unit, while public health is recognized as a community responsibility carried on by local government for community not for the benefit of any particular individual.

It must be clear that health promotion is a joint and interrelated enterprise with reciprocal benefits and closely cooperative professional participation, the end results being for the good both of the family or person under individual medical guidance and for the community as a whole, the *demos* or crowd-patient of the health department. These are generally carried on without conflict or controversy but rather in a spirit of professional rivalry and interdependence.

In the New England Medical Journal of February 22, 1951, I emphasized the necessity of Medicine in Government, The Social Instrument of Public Health, and in the Journal of the American Medical Association of January 5, 1952, I tried to clarify the distinction between Public Health and Medical Care.

At the meeting of the California Medical Association in Los Angeles in April, 1952 (Calif. Medicine, Nov., 1952), I did my best to answer some of the doubts and uncertainties of medical colleagues as to the respective spheres of Medical Care and Public Health Services. On this occasion, I listed some 14 objects of current public and professional concern which have been in recent years added to the traditional six basic

activities of the local health department in one or more communities.*

I believe that the health officer has a legitimate obligation to be informed and resourceful in seeing that his community misses no helpful aid of medical science for the prevention of these conditions so far as contemporary knowledge exists. It is not equally clear that it will be the local health department that is held responsible for the diagnosis and treatment of the person, individual and family for each of these conditions.

It is in the general community hospital and through the coordinated services of general and specialist practitioners of medicine today that we should expect the application of diagnosis and treatment of individual patients. By the use of mass measures of discovery of early unsuspected cases of preventable diseases, the health officer and his staff aided by popular publicity can share in the community or bulk measures contributory to those required of the clinician in family practice.

It is obviously of the first importance that any disease or group of aging, sick or disabled persons of sufficient number and condition to rouse public sympathy and active efforts is a proper subject for study, statistical, epidemiological, demographic and economic by the Department of Health of local, state or national government, to discover what if any are the preventable factors and how the knowledge of them may be put to work to reduce prevalence or disabling results or death from such diseases. Such studies do not require that the patients themselves be cared for by each local or state department of health, but can perhaps be best carried on by such institu-

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- * 1. Chronic sickness and disability in young and old.
 - 2. Aging, its prevention and protection.
 - 3. Rehabilitation of the physically and mentally handicapped.
 - 4. Treatment of crippled and disabled children.
 - 5. Rheumatic fever, prevention and management.
 - 6. Cerebral palsy, prevention and reconditioning.
 - 7. Multiple sclerosis, prevention and care.
 - 8. Cancer, prevention, diagnosis, treatment.
 - 9. Heart and circulatory diseases, prevention and care.
 - 10. Mental health, guidance and protection.
 - 11. Diabetes, detection and guidance.
 - 12. Alcoholism, management of addicts.
 - 13. Narcotic addiction, registration and control.
 - 14. Infantile paralysis, treatment and rehabilitation.

tions as are to be found in the national institutes of health and in our schools of medicine and our general hospitals. If we do not require constant concern with prevention by the Department of Health, we shall find the insistent demands of the sick diverting the slender professional resources of this department into directions for which health officers and their staffs were not trained and for which other physicians, nurses and medical institutions are much better qualified.

The public is quite naturally confused by the misuse of the popular phrase "health services", a mischievous short-cut term used by social and political propagandists chiefly to include care of the sick and prevention of disease. Medical care of the individual in health and in sickness can never be other than an intensively personalized service sought by the patient or family and provided by the independent and wholly responsible physician preferred by the patient, and at best long familiar with the performance of the patient in both sickness and health. To quote from the article in the *Journal of the AMA*, above referred to:

"The health department can well be, and generally is, the guiding community influence and can show the need and possibilities of remedy of preventable factors of disease and injuries without itself being charged with the operation of hospitals and dispensaries or with the care of the sick individual.

"The primary distinction between medical care as above described and what is properly called public health services is that in the former all attention, devotion, skill, and resources are focused on the particular person whose suffering calls on the conscience and on all humanitarian motives for attention. This is the oldest, best developed, and most mature and successful of the uses of medical art and science.

"In public health the servants of science are employees of government, not engaged to meet the momentary and personal necessities of a case of sickness, but to apply all knowledge of prevention of disease as it affects the people as a whole".

The sick, always to be with us, will certainly receive the best that medicine and social resources have to offer.

Not so, however, is the case with public health services which call for social imagination, scientific disciplines and administrative organization of a different and sometimes of a higher order. We are truly only at the threshold of endeavor to rid ourselves, and our successors of all age groups, of preventable diseases. We spend annually per capita on local health services today scarcely more than the price of a cocktail. Our bill for legally sold alcoholic beverages is about \$65.00 per capita of our total population, while we spend on the average less than \$1.00 a year per capita to support local public health services.

It is next to impossible to support a local health department to deliver services recognized as productive of life saving at its most efficient level for less than \$2.00 per capita annually.

Look at your state of Indiana, or if this embarrasses you, glance at the nation-wide picture and see where the 40,000,000 of our people dwell who have not full time medically directed public health departments at all.

The first level of self respecting national accomplishment for preparedness for life in peace, or for the emergencies of war, is a total coverage of the nation with areas of public health jurisdictions that will bring to every unit of population and to every square mile of area of our nation, the tangible benefits of the sciences of preventive medicine.

As of July 1, 1952, 72 percent of the country's population (nearly 109,000,000) was covered by what are defined as local health departments organized to give full time service. All or part of 1,560 counties (of the total 3,070 counties and D.C.) are included in the coverage, which is provided through 1,209 different city, county, multi-city, or multi-county health jurisdictions. In Indiana, all or part of 8 counties were served by 10 local health departments with 30 percent of the state's population. Four of these were city departments, 5 were single county and one was a two-county unit. Two departments serve fewer than 50,000 persons each; 5 between 50,000 and 100,000; and 3, 100,000 or more. Two of the units, with a total population of nearly 120,000, were without health officers.

We in this country have chosen a way of life of infinite variety and have left the choice to the voice of the majority. It is quite distinctly the responsibility of the medical and associated pro-

fessions to make clear to the public the scientific basis for the care of the sick and for health protective services. There is no greater danger facing our nation than a confusion and controversy of facts and opinions as to the best way to invest shrewdly and reap increasing dividends from the stock of knowledge accumulated by the sciences of preventive medicine and waiting to be implemented through the resources of individuals and of the local community. The progress of science will set at naught any plans or pressure for legislative limitation of the scope and functions of public preventive medicine.

There are a few and well tested social devices to bring common understanding as to the application of medical care and public health services, the methods, costs and results. It is time that we applied these to this unfinished business. The elements appear to me to be of three kinds, local government with its executive department of public health, community health councils representative of educated public opinion, and the local medical society with its membership organized to study local medical needs and resources for care of the sick and for public health. Comparable elements are desirable on a state basis.

Until there is substantial organization of public health departments at the local and state levels of government and a good variety of experiment and experience among them, the vague and mostly political platitudes offered as "national health plans" either by federal government spokesmen or by nationwide professional bodies are of no serious import and lack reality or competence. We have today no national plan for medical care or public health services worthy of the name, and are not likely to have any until we have applied ourselves successfully to the solution of some of the simpler problems of the home-town, the county, the state, district, trade area or transportation centers of our country.

In emphasizing repeatedly the problems of

total local community coverage by full time health departments, I would not have you think I ignore or depreciate the necessity of our state and federal health services. However, let me say that without the retail delivery system of local public health services everywhere completed, the federal and state health services will be seriously hampered. Federal services cannot replace state or local health departments. State health departments have as a major duty the development of local full time health units within which their supervisory consultant and collaborating services can have optimum effect.

No state can think of its citizens as enjoying the privileges and opportunity of an American way of life unless they have at their service in every community the sciences of preventive medicine provided through tax money as one of the indispensable executive departments of their own local civil government.

There need be no rivalry between the medical profession and officers of public health except in the process of doing their respective jobs in the closest cooperation. Neither legislatures nor the courts will hinder the freedom of the physician to expand his conquest of sickness nor limit health departments in extending their duties to new realms of preventive and constructive public health if each of these partners in the sciences of medicine respects the other's respective superiority and special competence and the two together devote themselves without stint to the public interest.

"Health is the first wealth". *There* is a slogan worthy of all manner of broadcasting. I commend it to you.

In closing let me urge upon health councils, voluntary health agencies and county and state medical associations to support publicly and vigorously the bill to be reintroduced in the 1953 legislature to provide state aid for local health departments as may be found necessary.



HOSPITAL RELATIONSHIPS OF THE GENERAL PRACTITIONER

MAURICE V. KAHLER, M.D.*

Indianapolis

THE RELATIONSHIPS of the general practitioner with his hospital involve a number of difficult problems. They concern not only the general practitioner and the hospital but the specialist as well. The obligations and responsibilities of the hospital, the specialist and the general practitioner need study because of fundamental changes in hospital administration and in medical education. Many of these changes have not been to the advantage of the general practitioner.

It is my intention to keep this discussion on a high plane and I wish to make known that I have the greatest respect and admiration for our specialists as a group. I am aware of the years of study and training, beyond that of the general practitioner, which are required of the specialist to fit him for his particular field. I also feel that the various specialties are absolutely essential to our system of medicine as it is practiced today.

My convictions are opposed to current medical teaching. I believe that the public interest demands that the number of specialists be limited and that these shall be highly trained. I also believe that at least three-fourths of all physicians should be well qualified general practitioners.

This paper is being presented because of a series of incidents, involving general practitioners, which have occurred in different cities in the state during the past few years.

In one of the larger hospitals several general practitioners were dropped from the staff; some were reinstated, others were not. Some were transferred from the active to the associate or courtesy staff; some had their original positions restored, others did not.

In two larger cities in the state a proposed over-all change in staff structure threatened to curtail drastically the activities of the general practitioners.

In one of our larger cities the general practitioners were classified alphabetically according to their abilities.

We have noted for years a growing tendency to limit those procedures which a general practitioner may perform in the hospital. We noted particularly that as the young men were admitted to the staff they were granted fewer adjunct privileges. This has not affected the young men alone. Recently in one of our larger hospitals it was proposed that the adjunct privileges of all general practitioners be limited to minor procedures.

It is evident that the status of the general practitioner in the hospitals of our larger cities is in a state of flux. To better understand his status we should discuss certain fundamental changes which have come about in our hospitals. They were brought about by three factors or forces. They were:

1. The program of hospital standardization.
2. Certification of specialists.
3. Resident training program.

The program of hospital standardization had its inception some 30 odd years ago and had as its primary purpose the improvement of the quality of surgery done in the hospitals. By complying with various requirements the hospitals in turn were accredited for intern training. This program expanded from year to year and no doubt has affected to some extent every hospital in this country and in Canada. It has brought about many changes some of which have directly affected the general practitioner. Decisions were made affecting us when we had no

* Presented at the 1952 Annual Session of the Indiana State Medical Association, Indianapolis.

voice to make known our approval or disapproval.

Today we general practitioners have a voice on the national level. That phase of hospital standardization which has to do with professional services is now the responsibility of a committee made up of four members from the American College of Surgeons, four members from the American College of Physicians, six members from the American Medical Association and two members from the Canadian Medical Association. Two members from the American Medical Association and one member from the Canadian Medical Association are general practitioners. It is our responsibility to keep our representatives on this committee informed as to what we feel is best for the general practice of medicine on a national level. On the local level it behooves us to participate actively in the deliberations of our hospital staffs.

Certification for the various specialties has been in effect for a number of years. It does not affect the general practitioner directly but the emphasis placed on certification for staff membership increases the prestige of the specialist throughout the hospital to the disparagement of the general practitioner. This is especially true in the teaching hospitals.

The residency training programs of our hospitals have expanded tremendously since World War II. They have expanded until in some hospitals there are almost as many residents as patients.

Indiana has a few large cities, several smaller cities and a large rural and small-town population. We do not have the need for a large number of specialists.

There are many very definite objections to a high ratio of specialists to general practitioners. The most fundamental and important of these is that relatively few people need the services of a specialist. For that and economic reasons the specialists continue to go into the larger cities even though the cities are adequately supplied. In such a situation specialists must devote much of their time to well patients and those who have minor illnesses. Complete, exhaustive and expensive study of those patients has no place in good medicine. It tends to increase rather than decrease the number of psychoneurotics

and hypochondriacs. It unjustly increases the cost of medical care. It further increases the shortage of hospital beds and keeps out or delays the entrance into the hospital of patients seriously ill. It fosters unnecessary surgery and excessive charges.

I believe very strongly in the value of post-graduate training of physicians. I feel we owe a deep debt of gratitude to our medical teachers, particularly those men in private practice who give generously of their time. However, I feel a situation is being created in this and other states which is definitely detrimental to good medicine. Over 50 percent of all physicians of Indianapolis claim to be specialists. (Indianapolis Medical Society Bulletin, February, 1949). Similar situations are developing in other cities over the state.

Following is some data on the intern and residency training program.

The Council on Medical Education and Hospitals in 1927 approved 278 hospitals for resident training and approved 1,766 residencies in those hospitals. In 1952 it approved 1,161 hospitals and 20,971 residencies.

The Council on Medical Education and Hospitals of the American Medical Association reported 6,821 interns on duty in the 1950-51 period. It reported 6,376 first year residents on duty in the 1951-52 period. There is no information available on the distribution of the 6,821 interns. For our purpose we may assume that the 6,376 residents came from the 6,821 group of interns. That leaves 445 available for general practice. It reported 159 residents in general practice. It reported 15,851 total residents of which 6,376 were first year and 9,475 were for two, three or more years. A large number of the first year men will be required to carry over into the second year residencies. Some will be available from the general practice residencies. How many of the others with training beyond their internships will be available for general practice? It is impossible to arrive at an accurate figure. From observation it is safe to assume that only a few will go into general practice. Of this we may be certain, the number available will fall far short of the number required for replacements if the general practice of medicine is to survive. These figures are on a national level.

REPORT OF THE COUNCIL ON
MEDICAL EDUCATION AND HOSPITALS

Year	Approved Hospitals	Approved Residencies*
1927 -----	278 -----	1,766
1937 -----	438 -----	3,202
1942 -----	662 -----	5,487
1947 -----	1,017 -----	12,003
1952 -----	1,161 -----	20,971

* Approved residencies include assistant residencies and fellowships.
1927 Medical School Graduates 4,035
1952 Medical School Graduates 6,135.

REPORT OF THE COUNCIL ON
MEDICAL EDUCATION AND HOSPITALS

Interns on duty-----	50-51 Period----	6,821
Total year Residents---	51-52 Period----	15,851
First year Residents---	51-52 Period----	6,376*
2 to 5 year Residents---	51-52 Period----	9,475
General Practice		
Residents -----	51-52 Period----	159*
Interns -----		6,821
First year Residents -----		6,376
		445

* Unknown number from these groups available for general practice.

It is evident from this report of the Council on Medical Education and Hospitals that the general practice of medicine will die out in the not too distant future if the present resident training program continues. Why are our educators and teaching institutions willing or desirous that this occur? I am at a complete loss as to the answer to this question. Somewhere in the past they have lost sight of the primary objective of our medical system. They have abandoned the practical for a utopian type of care which will be available only in the densely populated areas.

No doubt they justify their stand in the belief that the work done by the general practitioner is of inferior quality. That such is not the case I wish to present some factual evidence. From the data available it is evident that approximately 20 percent of the mothers delivered in Indiana are delivered by the obstetric specialist and 80 percent are delivered by the general practitioner. The following data was obtained from the Indiana State Board of Health. (Statistics from the other states follow the same pattern.)

(3)			
Year	Mothers Delivered	Deaths	Deaths per 1,000
1920	64,809	567	8.74
1930	61,032	370	6.2
1940	63,386	178	2.9
1950	93,256	61	0.7
1951	101,736	56	0.6

These results were obtained by a large number of men working under a multiplicity of conditions. For decades it has been the aim of obstetrics to obtain such results. I have no doubt but that the quality of work done by these same men in other fields of general practice is on a par with their obstetrics. It will be a misfortune to have the general practice of medicine lost because of our present teaching program. It would seem far more logical to utilize the greater part of our training facilities to better train our graduates for general practice.

No doubt some form of compulsion will be necessary to stop the present trend in medical education. A given number of years of general practice could be required before entering specialty training or a given number of years of general practice could be required before board certification. However, our educators, specialty boards, hospitals and schools are in no mood for compulsion. Such being the case we should at this time direct our efforts to informing all concerned as to what is occurring and the results which are to be expected.

I feel that every general practitioner of our State Association should be willing to assume a certain degree of responsibility toward the solution of this problem. We general practitioners have woefully failed to inform the public and the profession on the merits of the general practice of medicine and to inform them of our progress and accomplishments. Those people in particular who should be informed are medical students, medical teachers, medical leaders and the members of the governing boards of hospitals.

Too often medical students are led to believe that only inferior students become general practitioners. Medical students have a poor conception of the general practice of medicine. They are uninformed as to the enormous amount of good medicine practiced outside the walls of our hospitals. A large number of states are requiring their students to spend a period of time in the

office of a preceptor at some time during their school years. This could be a step in the right direction and go far toward acquainting the student with the practice of medicine other than by specialists.

I feel that a number of medical leaders and educators are not informed as to the progress made in general practice and see it much as it was 10 or 20 years ago. The same applies to the members of hospital boards whose medical world is apt to revolve around their institution.

In conclusion, I feel that the postgraduate training programs in this state should be directed primarily to the training of general practitioners and secondarily to the training of specialists.

If we had a normal ratio of general practitioners to specialists we would not have a shortage of physicians. We have a sufficient number of doctors. Our cities are crowded with specialists while the small town and rural areas are definitely in need of general practitioners.

For the physicians in the small town and rural areas there should be formulated a postgraduate training program which would give them partial training in the various specialties. It should be justified on the grounds that their communities cannot economically support any full-time specialists.

The output of those trained in the specialties has been so great that the general practitioners in the larger cities will probably continue to lose more of their adjunct privileges. They should retain medical, obstetrical and minor surgery privileges.

I believe I have shown why disturbances have occurred in the hospital relationships of the general practitioners.

Discussion by W. D. Gatch, M.D., Indianapolis

Overspecialization could well be the title of Doctor Kahler's paper. His discussion of this is clear and factual. He regards it as the chief disease of medical practice. He states its causes, symptoms, and proper treatment and plainly shows a fear that it may be incurable. I agree with all he has said. More than 20 years ago I asserted that the wild growth of specialization, if unchecked, would kill general practice and establish state medicine. Doctor Kahler has

clearly shown that nothing has been done to stop this growth and that it now threatens the very existence of general practice. He has discussed the bad effects of too much specialization, namely: (1) faulty distribution of physicians with too many in cities and too few in the country, (2) needless examinations and treatments causing needless increase in the cost of medical care, and (3) a medical service which for many reasons is becoming more and more unsatisfactory to the people, (4) Poor hospital relationships for the general practitioner.

Overspecialization is really *not* the *chief disease* of medical practice. It is only a *chief symptom* of the chief disease which is clearly Lay Domination of Medical Practice and Education. A paper on this subject I published in 1944 explains how the present situation came about. I quote:

"Fifty years ago the amount of money which the people paid for medical care was not large. They paid more to patent medicine companies than to their doctors. Little laboratory work was done. People were sent to hospitals only in case of serious illness.

"They were born at home, stayed at home when sick, and died at home. Hospital and health insurance were unknown. Specialists were few, and nearly all of them did general practice. Nearly all medical care was still given by the general practitioner. Medical colleges were conducted entirely by doctors. No effort had been made to enlighten the people on every fact of medical science. In short, the field of medical care was not exploited by laymen other than the vendors of patent medicines.

"Now all this has changed.

"Medical science has made spectacular advances which have fascinated the people.

"They have been told at great expense and by every possible means of instruction, chiefly under guidance by lay agencies, all that anybody knows and in most instances a great deal more, about all the mysteries of the human body and the ills which may afflict it.

"There has been a great construction of hospitals. The investment of money in them is tremendous. Their maintenance is a major industry. It is no longer customary to be born, to be sick,

or to die at home. These great events of life now take place in a hospital.

"An army of social and welfare workers has moved in between us and the sick poor. This is already claiming recognition as a distinct profession.

"The foregoing facts prove, among other things, that we no longer have undisputed control of medical care; that multitudes of laymen, in one way or another, now make a living out of it, and threaten to subjugate us; that we are in an ugly situation."

Since 1944 when I wrote the material just quoted the lay campaign against disease has increased tremendously in scope and intensity. It consists of a number of great drives to get money to control cancer, heart disease, insanity, tuberculosis, diabetes, poliomyelitis, venereal diseases, and arthritis. These are advanced by up-to-date nationwide advertising which excites terror of disease and fond hope of its control and cure, provided only that the people give enough money for this noble purpose. This advertising takes for granted that health and knowledge of disease are commodities which can be bought for a price. These drives have done much more harm than good. They have made us a nation of hypochondriacs. They exalt the specialist and discredit the general practitioner. I deem it unfortunate that they have the support of many of our leading physicians.

Doctor Kahler states that our medical schools are destroying the practice of general medicine. This is true. Laymen now control medical education. Many deans of medical schools are not physicians, and very few of those who are have ever had any clinical experience. I have heard

many of them say that the day of the general practitioner is over. They believe in specialization and in the use of mass-production techniques in medical practice. Control of the Veterans' Hospitals has increased their power.

The medical student of today gets all or nearly all of his clinical instruction from specialists who are full-time teachers. The disposition and professional environment of the full-time teacher inclines him to favor state medicine, for it would be like the practice he is already doing. His life is sheltered and his field of practice limited. He has little regard for the family doctor.

The medical schools are not performing their chief function, which is to train men for the general practice of medicine. They are organized to train specialists, and are not doing a good job of that. For the specialist should first of all be a good physician who is able to consider his patient as a complex psycho-physical organism, and he is not being trained to do this. I heartily agree with Doctor Kahler's suggestion that no man be certified as a specialist until he has had several years of general practice. A plan to do this would need to be nationwide in scope. To withhold the M.D. degree until the student has been in general practice for a given time would accomplish the same purpose and could be done by any medical school. Either plan would give us more general practitioners and fewer but better specialists. Thus the medical schools could give us all the physicians we need without accepting more students than they can possibly train.

Finally I commend Doctor Kahler for his support of post-graduate study by the general practitioner. The best and the only defense against state medicine is to give the people satisfactory medical care.



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AUTO CRASH INJURY RESEARCH

A SCIENTIFIC study to determine the etiological factors of injury in automobile accidents was originated by the Indiana State Police in 1950. The program has been conducted on a state-wide basis during the past year. A preliminary report by Mr. Hugh DeHaven, published elsewhere in this issue, indicates that the project is accumulating decisive information and promises to be successful.

The basic objective of the study is to determine the correlation between automobile design and passenger injury. It is the first such investigation to be made. When enough data has been assembled and studied, the results will be available for automotive designers. The auto industry has evidenced interest in the results, with the hope that safer automobiles may be designed for the future.

Cornell University was the pioneer in the field

of air crash injury research, and has contributed to many of the safety factors in the building of passenger aircraft. Experience acquired in study of air crashes and airplane design is aiding in solving similar problems in automobile accidents.

A four-page illustrated article appeared in *Collier's* on January 10 of this year. This is an indication of the widespread interest which the research has enlisted. Special note was made of the cooperation afforded by the medical profession in Indiana. The simplified medical report form was mentioned and its use by several other states was predicted.

Auto crash injury research is another first for Indiana. The Indiana State Police and Cornell University are requesting the continuing cooperation of Indiana physicians in furnishing medical information for this fundamental and life-saving research project.

ADMISSION TO MEDICAL SCHOOL

SIXTEEN thousand, seven hundred and sixty-three students applied for admission to U. S. medical colleges in 1952. Large as this number is (only 7,778 of them were accepted), it represents a decrease in the number of applicants for the third consecutive year.

In the two peak years, 1948 and 1949, over 24,000 students applied each year. Since then the number has fallen steadily. During this same period the aggregate size of the freshman class has increased slightly. Both of these changes has increased the percentage of acceptances during the past three years.

The acceptance rate in 1952 was 46 percent. Fifty percent of those applying for the first time were accepted. Thirty-eight percent of the 5,215 students who had applied in previous years and had failed of acceptance were accepted in 1952.

These and other interesting facts are reported by the Association of American Medical Colleges as a result of a study of applicants which is made each year by the Association. The first such study was carried out by Dr. B. D. Myers in 1926, when there were 10,006 applicants. The study has proved so useful that it has been reinstituted several times and is now an annual feature.

Indiana University School of Medicine is reported as accepting 150 students in 1952 from 460 applicants.

In all, 326 residents of Indiana applied to various medical schools in the U. S.; 188 of this

number were accepted. This betters the national average of acceptance considerably, and would seem to indicate that Hoosiers are well equipped for the stiff competition involved in gaining admission to medical education.

The Association's report points out that, while the overall ratio of applicants and acceptances seems adequate, there are some schools in 1952 where the number of applicants was not sufficient to allow the selection of a full quota of well qualified students. "Some medical schools had a wealth of good applicants while other schools which limit their applicants to geographical boundaries had to scrape the bottom of the barrel to secure a freshman class."

Multiple applications make an interesting study by themselves. An average of 3.4 applications were filed by each student. Fifty-nine percent of the total applicants applied to more than one school. The Association's figures seem to indicate some advantage to this procedure. "Of the group making a single application, 41 percent gained acceptance. Among those making two applications, 49 percent were accepted and in the group making three applications, 54 percent were accepted."

In the realm of super-applications there were seven students, each of whom applied to more than 35 schools; four of the seven were accepted. One man applied to 45 schools and was accepted by one of them. One girl applied to 40 schools and won three acceptances.

WELFARE MEDICAL AID CLAIMS

THE State Department of Public Welfare has issued a bulletin to encourage physicians and all others concerned with medical aid claims to file their claims promptly and at least once a month.

Accumulated claims will, of course, be paid by the Welfare Department. The advantage of submitting and paying claims each month lies in the fact that Federal participation in the claims will be at a maximum when they are paid monthly.

There is a ceiling on the amount of Federal

participation for each month. Credits cannot be carried forward to succeeding months. If monthly claims are filed the Federal credits will be used to the maximum. Bills accumulated for several months may exceed the Federal share and the State Welfare Department will lose the amount in excess since it cannot claim the unused credits for previous months.

For Federal reimbursement the claims must be filed within 60 days after termination of treatment or when patient goes off welfare rolls for any reason.

Editorial Notes

TESTIMONY given by J. William Wright, Sr., M.D., immediate past president of the Indiana State Medical Association, and Andrew C. Offutt, M.D., director of the Division of Communicable Disease Control of the Indiana State Board of Health, before the public hearing of the President's Commission on the Health Needs of the Nation at Detroit September 28, 1952 appears in Volume 5 of the Report to the President.

Selection of the statements of the two Indiana spokesmen for the medical profession was made from 50 presentations of testimony at Detroit. The volume is entitled "The People Speak—Excerpts from Regional Public Hearings on Health". Interrogation of Doctor Wright by Dr. Russell V. Lee, Palo Alto, California, a member of the President's Commission, is included.

Doctor Offutt's testimony was from the public health angle; Doctor Wright gave a comprehensive picture of health and medical situations in Indiana. The profession was creditably represented by Doctors Wright and Offutt, F. R. Nicholas Carter, M.D., South Bend, and Neal Baxter, M.D., Bloomington.

A recent feature article in the South Bend Tribune tells of the long years of service—more than 55—which Dr. Edwin D. Stuckman, New Paris, has given to the practice of medicine in his home community. The occasion for the article was the celebration by the veteran physician of his eighty-fifth birthday. Neighbors recall that the Elkhart county doctor worked tirelessly during the World War I influenza epidemic and Doctor Stuckman tells of the 2,200 babies he delivered in the New Paris area.

A certificate of distinction awarded him in 1947 by the Indiana State Medical Association on the occasion of completion of 50 years of practice is among his valued possessions. Doctor Stuckman, who is still seeing patients in his office, continues to exemplify the words of that

certificate which says, "who through his proficient and untiring ministry of the science of healing, for 50 years, has done honor to God, his community, his profession and himself."

Letter to the Editor

Editor,

The Journal of the Indiana State Medical Association,
Indianapolis, Indiana.

Dear Sir:

In the Journal of November 1950, beginning on page 1108, there was an article "The Responsibility of the Hospital for the Educational Stimulation of the General Practitioner". Time enough has passed since then to take stock of the situation that hangs thereon.

A program was set out in principle to change the general practitioner in medicine from one who knows less and less about more and more. As I read the article the plan was to bring the level of the continued education of the GP up to the present level of the specialists, unspecified. How has the plan developed, we well may ask?

It should be noted that I do not patronize the institution in question and have not since the writer of the article came to be in charge. I have been interested in the workings of this closed staff hospital and have based the following questions upon information given by members of the active staff. All doctors in Indiana and particularly in Indianapolis should be keenly aware of the implications contained in the paper as written and in the workings of the example hospital now some two years later.

Is it not correct that to extend educational advantages a hospital should include all possible members of the GP group of its city?

I am told that this hospital has reduced its GP staff membership, and specialist membership as well, repeatedly.

In order to encompass all qualified teachers for the benefit of its staff, should not a hospital broaden the scientific base of its staff membership? I am told that through staff reduction the teaching program is becoming more sterile constantly. There seems to be a recurring criticism: it is not wise to discuss even in debate certain medical questions that occupy the pages of many medical journals.

Does it increase or decrease the quality of the GP to reduce his "privileges" to the vanishing point; to the point where he becomes merely a referring center? I am told that many parts of medical therapy long practiced by certain GPs can no longer be employed by the self same men who were welcome to do just that, once upon a time.

Does it widen the educational horizon of a GP if his patients will not be admitted after he voices a complaint because of failure of service vital to his patient? The refusal of patients because their doctor was "against the institution" might well be a lever which, through abuse, could bring dangerous negligence into involuntary acceptance.

There is a Public Health aspect to all hospital matters. We of the State Association have the leading interest in such problems. Is it in favor of the public health for a hospital to recommend and practice a program of limitation under any guise, and particularly under the claim of widening the educational training of the general practitioner?

The paper mentions the work done in other states. I believe that our State Medical Association should take the matter of GP standing, education, and hospital privileges under close consideration; since we all are doctors and are not to be divided among ourselves under the artificial labels of folk not involved in the treatment of the sick.

Closed staff hospitals, under any name or claim, have not served the public and cannot. They cannot become part of the Public Health program of a State Medical Association or of the practicing doctors of the state. They cannot enter into any forward program

of universal training, because all medical training worth its name is voluntary, uninhibited, private, confidential, and not subject to scrutiny by lay outsiders.

May I recommend that we take open stock of the situation in Indianapolis for the purpose of measuring the effect of the responsibility of hospitals for the educational stimulation of the doctor,—not the general practitioner alone? An official report will be of great value in determining the kind of hospital the people of the state build, wherever they care to build in the future.

Sincerely yours,

Thomas B. Noble, M.D.,
4360 N. Pennsylvania St.,
Indianapolis 5, Indiana.

February 21, 1953

The Editor

Indiana State Medical Assn. Journal
1017 Hume Mansur Building
Indianapolis 4, Indiana

Dear Sir:

This may serve as a commentary of interest to other physicians and the people of Blue Cross and Blue Shield.

In this time when Blue Cross and Blue Shield are doing a magnificent job of holding the line against socialization of medicine, and when as we know there is much abuse of insurance coverage by individuals who present doubtful claims, it is gratifying to see an example of the opposite attitude, particularly if it comes from a representative of the medical profession, a member of the Vanderburgh County Medical Society.

Recently I have had occasion to engage the services of a local colleague for a condition which is of vital importance to me personally. This involved repeated procedures, lab work, and considerable time. Although my colleague could have collected on my Blue Shield coverage, he declined to do so, and preferred to render the service as a matter of professional courtesy. His intention, with which I concur, was to avoid burdening the much

abused plan any further, thereby preventing any further increase in premium rates.

I believe that this attitude deserves to be brought to the attention of physicians at large, and may also serve as a demonstration

to the general public that physicians are doing their part in making medical insurance work on an economical basis.

Very truly yours,
M.D., Indiana

Medical Panorama by the ASSOCIATE EDITOR

A CATECHISM ON CHIROPRACTIC

In New York there is at least one medical society committee which pulls no punches on the subject of licensing chiropractors by examinations prepared by a Board of Chiropractors, as witness the following page from the *Bulletin of the Medical Society of the County of Kings*, February 1953:

MEDICAL SOCIETY OF THE COUNTY OF KINGS AND ACADEMY OF MEDICINE OF BROOKLYN

10 REASONS WHY CHIROPRACTORS SHOULD NOT BE LICENSED—NOW OR EVER

1—Chiropractors ENDANGER THE PUBLIC HEALTH because they do not believe in the well-established germ theory of disease.

2—They claim they can prevent and cure infantile paralysis, tuberculosis, diphtheria, scarlet fever, pneumonia, syphilis, gonorrhea, and other contagious diseases by their so-called "manipulation of the spine." THIS CLAIM IS FALSE! Besides, it is impossible to manipulate the spine by hand. Too vigorous attempts to do so have caused fractures and even fatalities.

3—Chiropractors are unable to diagnose and fail to isolate contagious diseases, thereby allowing such diseases to be SPREAD TO OTHERS.

4—Chiropractors DO NOT BELIEVE IN VACCINATION even though vaccine protection against typhoid fever, lockjaw and diphtheria saved thousands of soldiers' lives during the WARS and has REDUCED CIVIL INCIDENCE to minimum occurrence.

5—Their diagnosis and treatment are based on a FALSE ASSUMPTION . . . an ASSUMPTION NEVER SUBSTANTIATED BY SCIENTIFIC EVIDENCE.

6—No matter how long their course of study . . . no matter what subjects they are taught . . . it

is AGAINST THE PUBLIC INTEREST to license them, thereby giving them "legislative recognition" which could ONLY SERVE TO MISLEAD AN UNKNOWN PUBLIC!

7—Including Basic Sciences in their curriculum, which actually have no place in chiropractic theory, is done for the purpose of PULLING THE WOOL OVER THE LEGISLATORS' EYES. Besides, these highly technical subjects are taught mainly by chiropractors who, themselves, are inadequately prepared to teach such subjects.

8—Chiropractic treatment DELAYS PROPER MEDICAL OR SURGICAL TREATMENT until it is OFTEN TOO LATE to save patients afflicted with a brain tumor, cancer, gall stones and other serious conditions. To believe that malaria, pernicious anemia, ptomaine poisoning, or an epidemic of cholera are caused by pressure on spinal nerves by supposedly dislocated vertebrae IS AN ABSURDITY! To attempt to treat such conditions by alleged manipulation of the spine is to GAMBLE WITH PEOPLE'S LIVES!

9—Licensing an unqualified practitioner of the Healing Art does not change the fact that he is STILL UNQUALIFIED.

10—Requiring chiropractors to pass a "Special Chiropractic License Examination" prepared by a Board of Chiropractors, such as is done in States where chiropractic lobbying succeeded in inducing legislators to grant such legal recognition, has FAILED TO PROTECT THE PUBLIC. Chiropractors are ILLEGAL AND NON-QUALIFIED PRACTITIONERS OF MEDICINE. THEY SHOULD NOT BE PERMITTED TO PRACTICE THEIR CULT!

MORRIS WEINTROB, M.D.,
Chairman, Sub-Committee on Cults,
Legislative Committee.

This appeals to us as a clear pointed statement of the true status of the whole matter.

Since the proposal to create a Board of Chiropractors appears at every Assembly of the legislature of Indiana, it behooves all Hoosier physicians to have a sort of catechism on the

subject prepared beforehand and kept in mind. In this way, no telling argument will be overlooked and no accusations will be made which cannot be substantiated.

REPORT ON EMERGENCY WORK

There have been a great many statements and misstatements concerning the furnishing of emergency service on a 24-hour basis by local (county) medical societies. Much of this verbiage is conjectural opinion rather than pertinent fact. The following information, gleaned by the *Bulletin of Allegheny County Medical Society* [Pittsburgh] from the *Connecticut State Medical Journal*, is therefore of great interest to all medical societies located in cities or towns large enough to be harassed by this problem:

One of the most complete and progressive reports on this problem that has come to attention is that of the emergency service sponsored by the Medical Society of the County of New York. Two hundred and fifty physicians were enrolled in their service in 1951 and in that year 4,500 emergency calls were made. Their Executive Secretary, Robert D. Potter,

stated that "the number of hypochondriacs or persons with trivial requests is not excessive."

The report includes a study of 2,461 consecutive emergencies serviced from August, 1951 to April, 1952. It discloses that 23% of the emergencies involved respiratory and 20% gastrointestinal conditions. Other percentages are reported as follows: neurological, 13; heart, 12.7; accidents, 8.5; miscellaneous, 5.7; obstetric-gynecologic, 5.5; alcoholic, 3.9; pediatric, 3.3; surgical, 1.3; and drug addiction, 1.1. The survey revealed that the greatest number of requests were received over week-ends and holidays and that the peak volume of calls came between 9 P.M. and 2 A.M.

The statement concerning "hypochondriacs or persons with trivial requests" should carry some weight since one would expect city life to develop its full share of such. It would be interesting if some of the larger emergency "services" in our state would keep and publish such information.



Richmond Library Seeks Complete File of Journal

The Morrison-Reeves Library of Richmond, Indiana would like to acquire a complete file of The Journal of the Indiana State Medical Association, and invites offers by mail from any one who cares to donate any or all of the 45 volumes. Shipping charges will be paid by the library. Donors are asked to write the librarian before shipping the books in order to avoid shipping charges on duplicate volumes.

President's Page

FELLOW MEMBERS OF I.S.M.A.:

WHY should Indiana's Workmen's Compensation Law, in operation since 1915, be amended as far as the method of selecting physicians is concerned? This statute provides for choice of physicians by the employer who is obligated to pay the insurance premium for the employee.

It has been stated from time to time that if the medical profession does not sanction free choice of physicians by the employee instead of the employer it would advance us a step nearer to socialized medicine. Such statements generate paradoxical headlines but when you read the bylines, this same paradox is contradicted. If Federal Health Insurance were enacted into law, the medical profession would insist on free choice of physicians for each citizen because each citizen would have deducted insurance premiums from his paycheck. The insured, therefore, pays the bill and has the right to select his physician. However, the chances are dubious that the free choice of physicians promised by the proponents of government insurance would be consummated. The political party in power might desire that the selection of a physician be decided by the indispensable precinct committeeman. However, if the government would underwrite and pay for the premiums, said government would have the right to select the taxpayer's physician. Certainly this is a hypothetical supposition.

Put yourself in the employer's shoes and analyze the rights of the employer in a system of free enterprise. In Indiana the employer is obligated by law to provide facilities to care for the insured employees and to pay hospital and doctors' bills. If the employee does not receive adequate medical care, an appeal to the employer usually brings prompt action because a disabled employee is a liability, to say the least. If the employees' physicians were selected by the government under a Federal Health Insurance Act, you can imagine how much red tape would be required to change physicians. The State of Wisconsin Compensation Law gives the employee a choice of three physicians, and the employer selects the panel of physicians. No doubt some physicians in Wisconsin are disappointed in that they are not selected but this would be true if the employee selected the physician. In the State of New York a Medical Practice Committee which consists of three physicians passes on the qualifications of any physician who is capable of handling industrial cases. Do you envy the pressure put on the members of this selection committee?

No doubt medical specialization is well done, if not overdone. And if we are honest about our limitations we must agree that industrial medicine requires training which the average doctor does not experience. You may know of cases which have not received conscientious attention but the opportunity of the employee to select his own physician will not correct oversights in medical judgment. It will multiply them. "To err is human" and one reason that we have become overspecialized is due in part to a desire to diminish errors. The medical profession is striving constantly to eliminate its faults and to improve its services to all patients. The patient's welfare is our prime consideration, and if the patient is not receiving adequate medical care, the fault is not embodied in the method of selecting the physician, but rather in the inadequacies of overworked physicians.

In a system of free enterprise, we try not to tolerate a policy or plan that interferes with the rights of others. Selfish interests rather than the welfare of the patient frequently underlie the desire to alter such a law. In view of this,

the American Medical Association long ago adopted a policy that the party who pays the bill is entitled to the privilege of selecting the physician. This is a workable principle which can be applied to similar future situations. Furthermore, the choice of a physician by the one who pays the bill presents us with a policy which will keep the medical profession out of a lot of trouble, all of which is evident if you take the time to study the pitfalls and impedimenta of other plans. Such a policy cannot be labeled a step toward socialism. As a matter of fact those who desire to foist government controlled health insurance upon the United States are in favor of a free choice of physicians by the employee. And, these advocates would not object to a policy of free service by salaried physicians. "Politics makes strange bed fellows" and we should beware of sharing a bed with those who are interested in themselves rather than in the lot of the man who earns a living by the sweat of his brow.

Paul D. Grimm M.D.

P. S. "Finally, brethren, whatsoever things are true, whatsoever things are honest, whatsoever things are just . . . : whatsoever things are of good report; if there be any virtue, . . . think on these things."

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

THE TAX ON HEALTH

Ohio's Mr. Bolton has introduced into the Congress a bill which, in our view, represents a sensible approach by Government to the health needs of the nation.

What he proposes is to allow deductions from income taxes of all medical and dental expenses, as well as costs of membership in voluntary medical insurance and hospitalization plans.

As the law is written now, only those over 65 may deduct all medical expenses. Below that age those who face heavy health costs may deduct only those medical bills in excess of 5 percent of their gross incomes. To say that this is unfair selectivity is to say the obvious. Medical costs are not generally arranged on an age scale any more than is the common cold.

Let's see how the deduction that is allowed works. Suppose a man with a family has a gross annual income of \$3,500 (the average factory wage in 1952 was \$3,540). If that man spends on doctors, dentists, medicine and hospital costs a total of \$175, he is out of luck and must pay income taxes on that amount. But if he spends a total of \$180 for the

same purposes—to make his family well or to keep them healthy or to prepare for future illnesses—the Government will let him deduct \$5. But he still pays income tax on the other \$175 he spent for his family's health.

Mr. Bolton's bill is appealing for other reasons. It is a part answer to the false lures of socialized medicine, and it doesn't put the Government in the business of issuing pills or listening through stethoscopes. It places before the taxpayer an inducement to see the doctor and the dentist while they've still got something to work on, too, by allowing the deduction.

As the law is now, the taxpayer actually pays taxes on his efforts to maintain or improve his health. Even business gets a better break from the tax-writers than this, for businesses can depreciate a building or a new piece of machinery.

Such a system as this doesn't make much sense to Mr. Bolton and it's a safe guess that it doesn't make sense to anyone who knows how it works. We hope his bill passes, for it's time the Government ceases taxing the health of the people.

—Wall Street Journal.

CORNELL STARTS ACTIVE SUMMARY OF INDIANA AUTO CRASH INJURY REPORTS

HUGH DE HAVEN*

New York

THE Department of Public Health and Preventive Medicine at Cornell University Medical College now is actively cooperating with the Indiana State Police in tackling a public health problem which has assumed epidemic proportions—namely, injuries in automobile accidents.

More than 21,000 persons were killed and 850,000 others were injured in passenger automobiles in 1951. Many of the 21,000 who died did not die instantly but required the utmost in medical care before succumbing to their injuries. However, an even greater medical problem was presented by the 850,000 injured, as this group includes the paraplegics, the permanently disfigured and disabled, who became lifetime responsibilities to their families and the nation.

Indiana state authorities are making every effort to prevent accidents by traffic control, highway engineering and education. The Indiana-Cornell Auto Crash Injury Research program is an additional safety study. This program is secondary to accident prevention. It assumes that as long as there are human factors in the accident equation—there will be accidents. The program recognizes that carelessness, foolishness, recklessness, fatigue, inexperience, intoxication and stupidity cannot be completely eliminated on our highways. It considers that safety objectives will not be fully achieved if efforts are not made to moderate human exposure to injury when accidents occur.

Preliminary studies by the Indiana State Police show that crash-injuries often are needless and excessive: many occur because design engineers and safety groups do not

have reliable data on typical causes of injury and, therefore, cannot assess current dangers and safety needs. Lacking, for example, is specific information on the frequency and severity of face injuries inflicted by wind-shields; chest injuries caused by pointed hubs on the steering wheels; skull fractures from impact against solid instrument panels; multiple injuries attributable to failure of door latches, and crushing injuries in rollovers due to inadequate support from the top.

These and other details of automobiles can be engineered and designed to cause less injury in accidents when data becomes available for identifying dangerous structures but, until engineers have such data for judging safety needs and undertaking improvements, your wife, your children and closest friends are potential victims.

The success of the Indiana-Cornell program hinges on obtaining brief, but reliable, medical information on injured persons. Accumulated data on the nature, location and frequency of crash-injuries—when correlated with analyses of accidents and reports on objects and structures which cause injury—will provide statistical evidence on causes of needless and excessive exposure to injury in automobile accidents.

An editorial in the May 1952 issue of *THE JOURNAL* urged Indiana physicians to assist the Indiana State Police in the initial phases of Auto Crash Injury Research by filling out reports on injured persons. Excellent cooperation has been afforded by the great majority of Indiana doctors. In a few highly informative accidents, however, doctors have not submitted reports. Perhaps these few doctors have not understood the importance of providing essential information on crash-injuries. Their thought, possibly, has been that medical reports would become a part of

* Director, Crash Injury Research, Cornell University Medical College, 1300 York Avenue, New York 21, New York.

the basic police report on an accident—or that the identities or interests of their patients would be involved in some undesirable way. We are pleased to advise all Indiana physicians that this is not the case.

Auto Crash Injury Research *medical reports* from Indiana will be excluded entirely from the police reports. Beginning April 1, all medical reports will be forwarded to Cornell University Medical College for study, IBM tabulation and correlation with accident details. These summaries will then be analyzed and the results returned to Indiana.

Auto designers unhesitatingly state that vehicles can be built with less lethal interiors, once the designers are given data on elements which are repeatedly responsible for injuries. Without data for estimating the nature and frequency of occurrence of crash-injuries, we will remain helpless in attacking one of the Nation's foremost endemic problems.

We urge that all Indiana physicians contribute to this important program by completing medical reports for Auto Crash Injury Research.

DRUG WHICH MAY CURE MALARIA BEING TESTED BY ARMY RESEARCHERS

DARAPRIM, a drug which has given indications of being the most effective agent ever used in the treatment of malaria, is being subjected to Army research studies, the Department of the Army announced recently.

For as long as one year after being infected by malaria-carrying mosquitoes, prisoners at the federal penitentiary at Atlanta, Georgia, who volunteered for experiments with Daraprim, showed no signs of malaria. Further test of the drug is needed.

Army physicians now use two drugs in fighting malaria. Chloroquine is used as a suppressant. Weekly doses of it have to be given. If doses are stopped, malaria will show up in men attacked by the relapsing form of the disease. A second

drug, Primaquine, is given to prevent relapses. Daraprim, however, gives indications of both suppressing and curing malaria.

Daraprim has been tested against some of the toughest known strains of malaria. Research personnel who tested Daraprim in Africa, treated every person in an isolated village where most inhabitants were infected with malaria. The villagers were cured within about two months. After that not one of the 100 mosquitoes captured in and around the village was found to have malaria parasites in its body.

The new drug is easy to take and no bad after effects have been observed. It is made up in tablet form about the size of an aspirin and is inexpensive to manufacture. At the present time, however, Daraprim is in limited supply.



150 STUDENTS SELECTED TO ENTER I.U. MEDICAL SCHOOL

FOR THE sixth successive year Indiana University has selected an expanded class of 150 students for admission to its School of Medicine.

The list was announced by Dean John D. Van Nuys. The class will begin its medical training next September.

Though existing buildings, classrooms and laboratories have an entering class capacity of 128 students, the University's medical school since 1948 has admitted the larger class to remedy as far as possible the state's shortage of doctors.

This places the I. U. medical school among the six largest in the nation on the basis of size of the entering class.

Next fall's first-year medical class was selected by an admissions committee composed of faculty members and practicing physicians after weeks of study of grades and medical aptitude tests and personal interviews of all qualified applicants.

Fifty-three Hoosier cities in all sections of the state are represented in next September's class most of whose members are now completing pre-medical work in various Hoosier colleges and universities.

On a reciprocal basis with other states admitting Hoosier students to their medical schools, I. U. will admit six top ranking students from other states and one from Nicaragua.

The students selected are:

Richard H. Akiyama, John W. Applegate, Barry L. Bowser, George E. Branam, William L. Breneman, Edwin C. McDaniel, Robert T. Maletich, David I. Miller, and Raymond R. Petruskas, Bloomington; Beverly Ann Alldredge, Henry R. Black, Clyde E. Blackard, Harold E. Booker, John R. Brayton, Jr., Robert M. Conlon, Jr., Robert D. Deitch, Francis E. Donahue, David Hilton, David H. Jones, James C. Jordan, John W. Jordan, Jr., Jerry J. Kurlander, Robert E. Lewis, Donald C. McCallum, Robert N. McCallum, Dan E. Meininger, Richard D. Moore, Howard W. Newman, George J. Ostheimer, Carl S. Ray, Donald B. Reibel, Gabriel J. Rosenberg,

Herman A. Schalk, Robert K. Smith, Richard B. Solomon, Morton E. Tavel, Helen Thomson, Leland F. Walter and Thomas E. Woerner, Indianapolis; Joseph E. Anderson, Hubert T. Goodman, Jr., Harry R. Miller, and Ansel W. Schmalhausen, Terre Haute;

Achilles P. Anton, Henry R. Eshelman, De-Von W. Frash, Jr., Jerry A. Freeman, John L. Hoffer, Charles E. Lavis, Richard A. Schaphorst, Richard C. Simons, Donald F. Stepniewski, South Bend; William D. Augspurger, Winchester; Robert E. Bahr, Stephen H. Glassley, Michael A. Hogan, Richard M. Laycock, and Lloyd H. Smith, Fort Wayne; Thomas D. Batteredton, Greensburg; Shaffer B. Berkshire, Jr., North Vernon; Richard D. Bibler, Robert C. Eissman, Richard E. Mann, and Richard L. Stump, Muncie; Margaret Bowers and Kenneth F. Isenogle, Kokomo; John M. Boyd, Logansport; Earl A. Braunlin, Charles D. Breedlove and Robert E. Strange, Marion; Herbert C. Brown, Robert E. Carter, Jr., Robert L. Harris, Donald R. Judd, Russell L. Judd, Algirdas J. Krisciunas, Eunice Maier, and Earle U. Robinson, Jr., Evansville; Lewis J. Brown, Bremen; Charles W. Bugh, William T. Luckey and Richard Troyer, Elkhart; George E. Bullington, French Lick; James R. Calvin and George A. Teaboldt, Jr., Peru; Max A. Capestany, Jr., Walter E. McDonald, James M. Platis, James I. Pregent, Jr., Melvin I. Roth, and Louis T. Tenta, Gary.

James E. Dailey, and Abe N. Roth, New Castle; Forest D. Daugherty and Jerry A. Ferguson, Clinton; Edward A. Davis, Daleville; William D. Deupree, Shelbyville; Robert V. E. Drennen, Richard B. Helfrich, Joseph D. Lloyd, and James E. Moneyhun, Anderson; Robert Durell, New York, N. Y.; Charles R. Echt, Edward R. Gabovitch, Robert E. Hammemann, and Thomas E. Lunsford, Hammond; Forrest D. Ellis, Deputy; Howard M. Faust, Jr., and Joe E. Gahimer, Alexandria; James G. Fipp, Rome City; Hansel O. Foley, Decatur; Gerald E. French, and Robert J. Warren, Lebanon;

Richard N. French, Jr., and Donald A. Girod, Bluffton; Jordan D. Haller, Pittsburgh, Pa.; Benjamin L. Harper, and Emilee Joyce Manning, Poseyville; Robert E. Hay, Myron S. Kennedy, Jr., Goshen; Frank W. Hayes and Chester L. Kroll, East Chicago; Eldon B. Hickman, Jr., Dunkirk; Phillip J. Holmes, Zionsville; William C. Kaag, Lexington; Robert D. Knoll, LaPorte; John S. Kolina and James A. Yaeger, Whiting; Manuel Largaespada, Managua, Nicaragua; Avis Lingeman, Brownsburg; Nick G. LoBue, Chicago Heights, Ill.; Walter B. Long, Jr., Danville; James E. Luckey, Columbia City.

Wayne S. Miller, Kewanna; Robert M. Parker, Hanover; John N. Pittman, Princeton; George F. Rapp, New Harmony; Ronald A. Restifo, Erie, Pa.; Joseph M. Shroyer, Vincennes; Kay J. Smallwood, Bedford; Robert K. Sommer, West Lafayette; Ernest M. Steury, Berne; Leman R. Stewart, Speedway; Miguel A. Taitano, Oakland City; Ralph B. Ullom, Jr., Urbana; William M. Waymire, Elwood; Emily Ann Weirich, Butler; Brockton L. Weisenberger, Ironton, Ohio; Otto W. Wickstrom, Stilesville; Charles R. Wyttenbach, Elmira, N.Y.

AMERICAN COLLEGE OF CHEST PHYSICIANS REPORT ON CHEMOTHERAPY AND ANTIBIOTICS

THIS report is not intended as a detailed treatise on the chemotherapy of tuberculosis and nontuberculous chest diseases but rather as a progress report or statement on currently accepted principles and regimens to serve as a general guide to the physician treating tuberculosis and other chest diseases. Perhaps it is needless to mention that with respect to some problems encountered there is definite difference of opinion. When such is the case, it is so stated. Other questions are as yet unanswered but likely will be in the course of time.

In most tuberculosis hospitals in the United States today the use of streptomycin-PAS therapy has become substantially routine treatment for all patients with active and potentially progressive tuberculosis. Recommendations of previous years that streptomycin-PAS treatment be deferred in those cases where other therapeutic measures likely would be successful have now been modified in the interest of achieving more rapid and more durable therapeutic benefits. The marked trend toward long-term antimicrobial

therapy has been noteworthy and this principle is now almost universally accepted.

Streptomycin and PAS Use in TB

Pulmonary Tuberculosis: The well established, generally accepted specific therapy for pulmonary tuberculosis at this time is intermittent combined use of streptomycin (or dihydrostreptomycin) 1 gm. intramuscularly two to three times weekly and NaPAS (the sodium salt of para-aminosalicylic acid) 12 to 15 gm. daily for prolonged periods. This regimen has proved to be very efficacious. Used in this manner the incidence of toxic phenomena (hearing loss with dihydrostreptomycin and vestibular disturbance with streptomycin) is lessened and the emergence of drug-resistant organisms can be greatly delayed. A minimum period of six to nine months is recommended, and many patients will benefit from much longer periods of 12 to 18 months or more, depending on the type of tuberculosis under treatment. Procedures such as pneumothorax and pneumoperitoneum when applicable should be induced rela-

tively early during the period of chemotherapy. Thoracoplasty and resection should be done at the optimum time during treatment. In most cases surgical resection should be deferred until after six to nine months—though there is some difference of opinion on this point, depending in part on the type of disease present and its response to chemotherapy. Resection should be followed by three months or more of chemotherapy. Obviously, in a disease as variable and unpredictable as tuberculosis, the optimum time for surgical intervention can be determined only after careful clinical and laboratory evaluation of the case by the physician and the chest surgeon. It is emphasized again and again that chemotherapy is *not* a substitute for rest and other proven procedures in the management of tuberculosis, but a very valuable adjunct and should be used as such.

Acute Miliary Tuberculosis: A combined daily regimen of streptomycin 1 gm. intramuscularly and oral NaPAS 15 gm. daily in three or four divided doses is indicated and is usually administered continuously for six months following remission as determined by symptomatology, chest roentgenograms, and bacteriologic examinations. Continuous, prolonged combined chemotherapy is to be stressed. If the patient does not tolerate oral NaPAS, parenteral PAS may be given, either intravenously or subcutaneously. Small quantities of hyaluronidase added to parenteral PAS aids in more rapid absorption when given subcutaneously.

Tuberculous Meningitis: During the early acute phase of the disease streptomycin intramuscularly 2 gm. daily and oral NaPAS 15 gm. or more daily is recommended. When the acute phase is over—usually after a few months—the dosage of streptomycin may be reduced to 1 gm. daily and the regimen continued for a year or more. Streptomycin sulfate or streptomycin calcium chloride is preferred to dihydrostreptomycin when higher daily doses are used for prolonged periods because the former is less likely to cause serious neurotoxic reactions than the latter. Until recently it has also been considered standard practice to use streptomycin intrathecally daily for several weeks, then every

other day for several weeks more, in doses ranging from 50 to 100 mgm. per injection. However there is a growing conviction among a number of investigators that intrathecal streptomycin is not only unnecessary but may be undesirable on the ground that: (1) serious reactions and even deaths have been reported as a result of intrathecal streptomycin therapy, (2) spinal fluid drug levels are well above the reported *in vitro* bactericidal level required, (3) patients do not accept this treatment well over long periods, and (4) results in the treatment of meningitis in adults with and without intrathecal streptomycin appear to be comparable. Further research and study is necessary to resolve this problem, but there is reason to hope that intrathecal therapy will be found unnecessary as is the case in so many forms of nontuberculous meningitis. Reports on the intrathecal administration of tuberculin and fibrinolytic substances appear to be favorable but their role in therapy must await further investigations. Preliminary reports on results of the use of isoniazid in treatment of tuberculous meningitis, if confirmed by longer periods of observation, will undoubtedly modify the present therapeutic approach to this form of the disease.

Status of Isonicotinic Acid Hydrazide

There has been tremendous interest in this antituberculosis agent by physicians as well as the public since its dramatic—and unfortunately premature—announcement by the newspapers in February, 1952. It seems particularly important that its present status be critically evaluated at this time, based on the latest available studies by experienced investigators, and that a report be made to the members of the College and other interested physicians who may have occasion to treat tuberculosis.

General Considerations: Isoniazid, is an extremely potent antituberculosis agent, both *in vitro* and *vivo*. It is bacteriostatic *in vitro* in concentrations as low as 0.05 mcg/ml. In experimental tuberculosis in animals it has proved equal or superior to streptomycin as a therapeutic agent. Its toxicity in man is relatively low in dosage ranges of 3 to 5 mg/kg body weight. Some of the more commonly

occurring side reactions in this dosage range are constipation, hyperreflexia, positional hypotension and dizziness. Some workers are exceeding these dosages considerably and report no appreciable increase in toxic reactions except in elderly patients. Other investigators caution against the higher dosages because of the potential toxic effect on the central nervous system. Particularly in epileptics is caution urged; also in patients with pre-existing kidney dysfunction. Whether the higher doses are more effective therapeutically remains to be determined. Certainly at this time, the optimum dosage has not been established.

No serious disturbance of liver or kidney function has been reported as yet. In only an occasional patient are toxic side reactions sufficiently severe to necessitate discontinuing the drug. However in view of some reported instances in which serious complications have occurred during its administration, the committee emphasizes the need for vigilance and careful observation of patients receiving it.

Isoniazid administered orally is rapidly absorbed from the gastrointestinal tract, from one-half to three-fourths of the ingested dose being excreted by the kidney within 24 hours. It can also be given intravenously or intramuscularly if necessary. It permeates body tissues and fluids in effective concentration (which is especially important in tuberculous meningitis). It has a wide margin of safety with reference to therapeutic ratio. Drug resistant organisms are reported to emerge in a majority of cases after two or three months treatment with isoniazid alone. Though the relationship of the emergence of isoniazid-resistant organisms to the clinical picture is not as yet clearly defined, the committee feels that until conclusive evidence is found to the contrary, it must be assumed that the emergence of isoniazid resistance probably has the same ultimate clinical significance as has the emergence of streptomycin resistance. For the time being, until further careful studies yield the answer to this problem of drug resistance, the use of isoniazid *alone* is *not* recommended, except in investigational work. It is the opinion of the committee that isoniazid will probably find its greatest usefulness when ad-

ministered in combination with streptomycin and PAS.

Though much remains to be learned about isoniazid, considerable information has been accumulated and the committee feels that certain tentative conclusions may be drawn at this time.

Isoniazid is not a miracle cure for tuberculosis and is not recommended as a substitute for such measures as bed rest, collapse procedures and appropriate surgery. It cannot be emphasized too strongly that tuberculosis requires planned, integrated treatment with rest, chemotherapy and surgical intervention when indicated.

Information obtained both from published reports and from communications from many experienced investigators in the United States and Europe indicate that—

In pulmonary tuberculosis use of isoniazid results in early symptomatic improvement, often dramatic with reduction in fever, cough and expectoration. The appetite improves and gain in weight occurs frequently. Some investigators report that roentgenographic improvement compares favorably, in similar types of lesions, with that obtained with streptomycin and PAS for similar periods. Other workers protest that isoniazid, though effective in producing x-ray improvement, is not the equal of streptomycin and PAS in this respect. Isoniazid has proved useful as an "umbrella" in resective surgery in patients whose organisms are streptomycin-resistant. Roentgenographic improvement in streptomycin-resistant cases has proved disappointing in a large majority of patients studied.

In tuberculosis of mucous membranes, e.g. tongue, laryngeal and tracheobronchial, the response to isoniazid is similar to that with streptomycin and PAS.

In tuberculosis of the genitourinary tract, serous membranes, glands, and in tuberculous sinus tracts, reports are too few and the studies of too short duration for adequate evaluation. However, in general, they tend to be favorable thus far.

Acute miliary tuberculosis reports to date indicate that results with isoniazid, in oral doses of 5 to 7 mgm/kg body weight daily

are approximately equal to those obtained with streptomycin and PAS for similar periods. In one series of 12 patients treated for periods of three to nine months no relapses were reported. While such progress reports are most encouraging, other evidence suggests that this form of the disease may best be treated by combining daily streptomycin intramuscularly, NaPAS orally and isoniazid. The committee tends to favor this combined regimen until such time as further investigation yields the answer to this question. Treatment should be started early and continued for at least one year.

In tuberculous meningitis also, preliminary reports indicate that results with isoniazid alone in daily oral doses of 5 to 7 mgm/kg body weight are approximately equal to those obtained with streptomycin and PAS given for similar periods. Symptomatic improvement is rapid and dramatic, and spinal fluid cultures are usually negative for tubercle bacilli after the first month of treatment. The relapse rate among patients who survive for two months or more is thus far reported as slight, though this may increase with further observation. In view of such encouraging reports with the use of isoniazid alone, the committee believes for the time being at least, a regimen should be recommended which combines daily isoniazid orally, streptomycin intramuscularly and NaPAS continued for a year or more.

Treatment of Childhood Tuberculosis

The use of chemotherapeutic agents in the treatment of active primary tuberculosis is still rather controversial. Some believe that streptomycin and PAS should be used in *all* cases proved to be active. However, it must be remembered that most cases run a benign course and by treating every such patient many workers feel that the efficacy of these drugs may be lost, due to the development of drug-resistant organisms, in the event that reinfection type tuberculosis develops later. Much remains to be learned regarding this question, but certain observations can be made that are consistent with current good practice. Careful supervision of the patient, including frequent chest x-rays should be

maintained. When progression is noted by serial x-rays, when there is evidence that retrogression is not proceeding at a satisfactory rate, or when the patient is not doing well clinically, chemotherapy should be instituted without delay. Patients showing massive roentgen shadows of collapse due to a hilar node, the so-called "epituberculosis," should be treated. Every effort should be made toward re-expansion or resolution in these types to prevent the serious complication of bronchiectasis which so often ensues. Should bronchiectasis occur nevertheless, appropriate antibiotics are indicated to hold the secondary infection to a minimum. Moreover, all types of tuberculosis of bones and joints, of the genitourinary tract, and generalized lymphogenous tuberculosis when complicating the primary infections, should be treated immediately. Obviously all primary tuberculosis complicated by miliary or meningitic spread should be treated immediately and vigorously. Children usually tolerate streptomycin well and have few reactions. Treatment with streptomycin and PAS may be extended as long as a year. Isoniazid has not yet been used extensively enough in children for definite evaluation at this time.

Minimal Pulmonary Tuberculosis: Minimal active pulmonary tuberculosis, particularly of the exudative type, should receive early and prolonged chemotherapy with streptomycin and PAS for a minimum of six to nine months—perhaps longer. A proper rest regimen should be combined with chemotherapy for best results. Whether chemotherapy in such cases may be considered definitive or whether wedge resection should be combined with chemotherapy as recommended by some workers is still a much debated question at this time. Likewise the place of isoniazid in minimal tuberculosis remains to be evaluated.

Other Anti-Tuberculosis Agents

Cortisone and Tuberculosis: There is now general agreement that cortisone has no place in the treatment of tuberculosis. Because it can cause wide-spread dissemination of even apparently inactive tuberculosis, physicians are cautioned against its use for other diseases in patients with any evidence of tuber-

culosis. Even in the absence of known tuberculosis, chest x-rays should be taken before and several weeks after hormone treatment. If cortisone *must* be given for a very serious nontuberculous condition in a patient with tuberculosis, it should be combined with the use of streptomycin and PAS.

Other antituberculosis agents are mentioned briefly in the following paragraphs. However it appears clear that the development of isoniazid has reduced the frequency with which these agents of marginal value need to be called upon.

T.B.I. (amithiozone) in doses of 100 mgm. daily has demonstrated definite but limited benefit in the treatment of patients with advanced pulmonary tuberculosis. Toxic and allergic reactions, including progressive anemia, granulocytopenia and toxic hepatitis, occur with sufficient frequency to limit its usefulness and necessitate frequent laboratory examinations. It is not as effective as PAS with streptomycin and its use should be limited to patients resistant to streptomycin and PAS or where streptomycin and PAS cannot be employed because of toxic or allergic reactions. Bacterial resistance to T.B.I. develops frequently following six months of treatment with 100 mgm. daily.

Viomycin is still under investigation and shows some promise but is not recommended for general use at this time because of toxic manifestations, such as allergic phenomenon, renal irritations, vertigo and electrolyte changes.

Pyrazinamide is a drug that has shown early promise as an antituberculosis agent. The symptomatic response is similar to that of isoniazid but drug resistance occurs early, usually in six to eight weeks. For this reason its use is limited.

Terramycin when used in combination with streptomycin is reported to delay the emergence of drug resistant organisms and may find an occasional place as a substitute for PAS in cases where serious intolerance to PAS occurs.

Neomycin is considered too toxic for use in the chemotherapy of tuberculosis.

Pulmonary Mycoses

Reports during the past year indicate that both stilbamidine and undecylenic acid have a favorable effect in systematic blastomycosis. The relative infrequency with which the less common mycotic pulmonary conditions are recognized gives no opportunity to observe case series large enough to permit critical analysis. This is a field where the reporting of even one case history is important. As for the more commonly recognized infections, such as coccidioidomycosis, nothing of import has been added. In the treatment of fungal disease of the lung it is considered essential that "antibiotic cocktails," or running the gamut of therapy, be not instituted until a definite diagnosis has been made, since such a procedure not infrequently obscures the correct diagnosis.

Non-Tuberculous Pulmonary Diseases

The following agents are of practical value in the medical management of diseases of the broncho-pulmonary tree: penicillin, streptomycin, the broad-spectrum antibiotics, consisting of aureomycin, terramycin and chlormphenicol, bacitracin, polymyxin, the sulfonamides, and the enzyme solutions, tryptar and varidase.

Penicillin is the drug of choice in the majority of pulmonary infections. It is most useful against the gram-positive organisms. The best method of administration is the intramuscular route, using 100,000 units every three hours and continuing therapy until temperature is normal for 72 hours. Oral penicillin may be used but in doses five times as large as those used parenterally. It should not be relied upon in severe infections. Neo-Penil, a new penicillin derivative for intramuscular use, produces much larger concentrations of penicillin in lung tissue, and promises to be of considerable value in chronic pulmonary infections due to penicillin-sensitive bacteria.

Streptomycin is of value in pulmonary infections due to gram-negative organisms, particularly Friedlander's bacillus and *Pasteurella tularensis*. It should be given 1 gram intramuscularly every six hours for the first several days and then 1 gram daily for an

other week or so. In an occasional patient higher doses may be required.

Aureomycin, terramycin and chloramphenicol, the broad-spectrum antibiotics, all have a very similar action. They are effective in primary atypical pneumonia, ornithosis, rickettsial diseases, bacterial pneumonia, tularemia and Brucella infections and those due to the salmonella species. Gastrointestinal symptoms and secondary monilial infections are relatively common following the use of aureomycin and terramycin. A dosage of 250 mgm. every six hours instead of the usual 500 mgm. definitely lessens the toxicity of the drugs, without apparently interfering with their effectiveness. Because of the increasing number of reports of aplastic anemia following the use of chloramphenicol, the latter should be used with caution.

Bacitracin is effective in lobar pneumonia, given in doses of 30,000 to 50,000 units every six hours for three to 12 days. Because of its nephrotoxicity, it should be used only in patients whose infections do not respond to penicillin and other less toxic antibiotics.

Polymyxin is effective in infections caused by *Ps. Aeruginosa*, *A. Aerogenes*, *K. Pneumoniae*, *Esch. coli* and *H. Influenzae*. It is a toxic drug and should be limited to severe pulmonary infections not responding to other measures.

The sulfonamides have been relegated to a secondary place since the introduction of the antibiotics because of their potential kidney effects. However, they are highly effective in many bacterial infections of the lung and bronchial tubes, due to gram-positive organisms. They may enhance the value of penicillin.

Aerosol antibiotic therapy may be of value in chronic bronchitis, bronchiectasis and lung

abscess. Difference in reported results may be due to technique. A recent addition to aerosol therapy is the use of streptococcal enzyme solution and trypsin therapy in the form of a spray. The effectiveness of these enzymes is under investigation.

The enzyme solutions, varidase or tryptar, have now been accepted as valuable adjuncts in the treatment of pyogenic empyema. They are used in conjunction with antibiotic and surgical therapy when the latter becomes necessary.

General Considerations

Cultures of the sputum should always be obtained when possible. This is particularly important in severe and chronic infections. Sensitivity tests of cultures should be done in serious and long-standing infections that do not respond quickly to therapy.

Indiscriminate use of antibiotics especially in mild infections should be avoided. There are two serious objections to the unnecessary use of such agents. The first is the development of resistant organisms. The second objection is a change in the bacterial flora, such as a predominance of monilial organisms when aureomycin or terramycin is used, or a predominance of gram-negative bacteria following penicillin. Such therapy may upset the balance of nature.

Combined therapy should be used in serious infections when it appears necessary. It should be kept in mind that there is experimental evidence that there may be antagonism between the antibiotics such as penicillin and chloramphenicol. Sensitivity testing may be necessary in severe longstanding infections in order to determine the best possible combinations of therapy.

—*Diseases of the Chest*



A.M.A. ANALYZES PROPOSED EXTENSION OF DOCTOR-DRAFT LAW

THE A.M.A. Council on National Emergency Medical Service has just completed an analysis of the doctor-draft bill, prepared by the Department of Defense to extend the "Doctor-Draft Law" beyond its current expiration date of July 1, 1953.

The council's analysis indicates that the proposed bill would:

- (1) Extend the "Doctor-Draft Law" to July 1, 1955.
- (2) Set up two priority groups—(a) non-veterans and (b) veterans; also retain liability of those physicians now registered and classified in priorities 1 and 2.
- (3) Group 1 to go by age—youngest first. Group 2 to go by service—those with shortest service first. Present priority 1 and 2 men to go as their deferments expire.
- (4) Retain maximum induction age of 51.
- (5) Retain 24 months as required period of service.
- (6) Provide for deferments to maintain national health, safety and interest.
- (7) Define military service to include enlisted and commissioned service since September 16, 1940, except: (a) Army Specialized Training Program, V12 or Army Air Force College; (b) internship and residency training or senior student programs.
- (8) Excuse from registration liability any physician who is a member of a reserve component.
- (9) Recognize service during World War II with countries which were allies of the United States.
- (10) Exclude from any liability under the Act registrants or reservists who had 12 or more months of service since June 25, 1950.
- (11) Permit the commissioning of aliens.
- (12) Authorize the continuation of the national, state and local advisory committees to the Selective Service System; give them added authority with respect to residents and faculty members.
- (13) Extend until July 1, 1955 authority of the Secretary of Defense to transfer reservists between the Armed Services.
- (14) Terminate reserve commissions *automatically* upon completion of stipulated active duty. This provision would be retroactive to September 9, 1950.
- (15) Authorize recall of reservists at rank "commensurate with professional education, experience or ability." Current limitation on number of higher grades would be waived for physicians.
- (16) Withhold \$100 extra pay per month from those registrants "inducted" even though later commissioned.
- (17) Continue authority of President to recall medical, etc., reservists until July 1, 1955. Those with 12 or more months of service since June 25, 1950 would be excused.
- (18) Provide that reservists with 12 or more months' service since September 16, 1940 serve only 17 months.

The bill would not:

- (1) Specify any maximum age for liability to register. In the present law maximum age for registration is 50.
- (2) Take cognizance of *new* registrants who would fall in present priorities 1 and 2.

- (3) Make provision recognizing allied service in World War II retroactive.
 - (4) Make provision permitting a reduced period of service (17 months) in certain cases retroactive; thus would not help priority 2 men.
 - (5) Require registration of non-medical reservists.
 - (6) Permit a reservist to keep his commission even if he wanted to.
- Secretary's Letter
American Medical Association

PREMARITAL SEROLOGY

L. E. BURNEY, M.D.*

Indianapolis

EFFECTIVE July 1, 1953, physicians will be required to pay \$1.50 for *premarital* serologic examinations submitted to the laboratory of the Indiana State Board of Health. This requirement is included in S. B. 205, known as the "Health Administration Act of 1953" enacted by the last session of the General Assembly.

The provision reads as follows: "... in all cases in which the laboratory of the State Board of Health performs any standard serological test for an applicant for a marriage license, it shall charge a fee of one dollar fifty cents (\$1.50). All sums so collected shall be paid into the treasury of the State of Indiana so often as is convenient but at least once each month."

Plans for the collection of this fee to conform to this new Act are being developed and will be sent to every physician in the state before the effective date of this law—July 1, 1953. Please note this new law applies only to premarital serology.

This provides a further opportunity to again urge physicians to utilize to the fullest extent local, private, and hospital clinical

laboratories for premarital and other serologic examinations. Our laboratory services are available, of course, to every licensed physician in the state, but it is believed that our serology should be limited to those patients who would find it difficult, if not impossible, to pay for the service. Assumption by local laboratories of a large segment of serology now performed by us would enable your State Board of Health laboratory to provide other services which are not now provided either by private or official laboratories. During the past few years there has been an increasing demand by physicians for laboratory diagnostic aid in virus diseases. Some exploration of this idea has been done co-operatively with the Indiana University Medical Center, but our budget prevents us from adding any additional services unless we can decrease some of the existing services.

Better use by physicians of their local laboratory for serologic examinations will strengthen existing laboratories, aid in the establishment of new ones, and at the same time enable the State Board of Health to continue its serologic evaluation program of local laboratories and to perform other valuable services to physicians not now available from either source.

* State Health Commissioner, Indiana State Board of Health. Paper prepared for publication in THE JOURNAL of the Indiana State Medical Association.

AWARD OF MERIT

American
Medical
Education
Foundation

James W. Denny, M.D.

*For your outstanding
contribution to the
preservation and
continuance of the high standards
of medical education in the
United States of America*



1952 A.D.

James W. Denny, M.D.
PRESIDENT
James O. Ritchey, M.D.
VICE PRESIDENT
Herbert H. Inlow, M.D.
SECRETARY-TREASURER

FOR YOUR OUTSTANDING CONTRIBUTION . . .

Surprise presentation of the above Award of Merit—the second to be presented in the United States—was made Sunday, April 19, to James W. Denny, M.D., Indianapolis, chairman of the Medical Education and Hospitals Committee of the Indiana State Medical Association, for his outstanding service in connection with the continuing campaign of the American Medical Education Foundation.

Presentation was made by Hiram Jones, director of the American Medical Education Foundation, Chicago, at an organization meeting in the Riley room of the Claypool Hotel, Indianapolis. Members of Indiana State Medical Association from throughout the state who will carry on the drive for funds to be distributed to the 79 medical schools to insure adequate educational facilities for medical students, were present.

With Doctor Denny presiding, plans were made to proceed with personal solicitation among the state's physicians to attain the 1953 goal of \$50,000 as Indiana's quota of the national fund.

The award was made in recognition of Doctor Denny's work in raising funds during 1952. Other Indiana certificates will be presented soon to James O. Ritchey, M.D., Indianapolis, and Herbert H. Inlow, M.D., Shelbyville, for their outstanding contributions to the fund.

The first Award of Merit was presented to Louis D. McGuire, M.D., Omaha, Nebraska.

Program

American College of Surgeons, Indiana Chapter

ANNUAL MEETING

8:30 A.M. to 5:00 P.M. WEDNESDAY, MAY 13, 1953

AUDITORIUM, MEDICAL SCHOOL BUILDING, INDIANA UNIVERSITY
MEDICAL CENTER, 1040 WEST MICHIGAN STREET, INDIANAPOLIS, INDIANA

CARL H. McCASKEY, M.D., *President, Presiding*

All members of the Indiana State Medical Association are welcome to attend the annual meeting of the Indiana Chapter, American College of Surgeons. Registration starts at 8:30 a.m. There is no registration fee. The program will be concluded with a dinner in the Ballroom of the Columbia Club at 7:30 p.m.

Scientific Program

- 9:10 A.M. "Treatment of Ruptured Intervertebral Disc"
Paul Merrell, M.D.
- 9:30 A.M. Discussion
- 9:35 A.M. "Carcinoma of the Lung" (Color Motion Picture)
Wayne Carson, M.D.
- 9:55 A.M. Discussion
- 10:00 A.M. "Anterior Resection of Lesions of Colon"
Out of City Speaker
- 10:20 A.M. Discussion
- 10:25 A.M. "Present Day Treatment of Head Injuries"
Warren C. Hastings, M.D.
- 10:45 A.M. Discussion
- 10:50 A.M. "Surgical Treatment of Carcinoma of the Breast"
Cleon A. Nafe, M.D.
- 11:10 A.M. Discussion
- 11:15 A.M. "Some Experiences in the Management of Inflammatory Lesions of the
Pancreas in a Hundred and Fifty Bed Hospital"
Mell B. Welborn, M.D.
- 11:35 A.M. Discussion
- 11:40 A.M. "Glaucoma"
J. V. Cassady, M.D.
- 12:00 Noon Discussion
- 12:05 P.M. "Studies on the Closure of Defects of the Cardiac Septa"
Harris B. Shumacker, Jr., M.D.
- 12:25 P.M. Discussion
- 1:45 P.M. "Present Day Status of Radical Mastoidectomy"
Ralph J. McQuiston, M.D.
- 2:05 P.M. Discussion
- 2:10 P.M. "Mitral Valve Commissurotomy" (Color Motion Picture)
J. V. Thompson, M.D.
Edwin R. Eaton, M.D.
- 2:30 P.M. Discussion
- 2:35 P.M. "Treatment of Burns"
Harold M. Trusler, M.D.
- 2:55 P.M. Discussion
- 3:00 P.M. "Recent Observations in Experimental Cardiac Surgery"
J. K. Berman, M.D.
- 3:20 P.M. Discussion
- 3:25 P.M. "Treatment of Atresia of the Esophagus"
J. Stanley Battersby, M.D.
- 3:45 P.M. Discussion
- 3:50 P.M. "The American College of Surgeons"
Paul R. Hawley, M.D., The Director
- 4:10 P.M. Discussion

Deaths

Martin Frederick Schick, M.D., 91, died on March 10 in his Fort Wayne residence. He had been ill five days and had continued his office practice until that time. Doctor Schick, who attended Concordia College and was graduated from New York University Medical College in 1882, practiced for 10 years in Frankenmuth, Michigan. He then took a post-graduate course in Berlin and came to Fort Wayne in 1898 where he had been in continuous practice for 55 years. Doctor Schick was a member of the Fifty Year club of the Indiana State Medical Association, an associate member of American Medical Association and had been a member of Fort Wayne Medical Society for many years.

Samuel J. Petronella, M. D., 44 East Chicago specialist in industrial medicine, died April 1 in his home from a heart condition which he had hoped to alleviate by a two months rest in Florida. He had returned to East Chicago just a week prior to the fatal attack. Doctor Petronella was a graduate of New York University and the Royal University of Rome where he received his M.D. degree in 1934. He came to East Chicago 17 years ago to serve his internship at St. Catherine's hospital, following which he established his practice in that city. He was formerly associated with Dr. D. R. Johns but since 1944 had been in practice with Dr. M. F. Arnold. Doctor Petronella had been active in medical society groups, serving the state association in 1945-46 on the physical therapy committee and in 1950 as a delegate to the state convention. He was a member of the American Association of Industrial Physicians and Surgeons, the International College of Surgeons, Lake County Medical Society, the Indiana State and American Medical Associations.

Richard E. Estlick, M.D., 42, Fort Wayne physician and surgeon since 1940, died April 6 in Lutheran Hospital, Fort Wayne, where he had been a patient for one week. He had been ill just two weeks before entering the hospital. Doctor Estlick, a native of Whitley county, was a graduate of Indiana University School of Medicine in 1935 after which he practiced for one year in Millersburg, then returned to I. U. for specialized eye, ear, nose and throat training and also served as a resident physician at the medical center and at General Hospital, Indianapolis. In 1942 he was commissioned in the U. S. Air Force. He served as a flight surgeon in the North Atlantic theater of operations and was discharged in 1946 as a captain. He returned to Fort Wayne in 1946 and had since become a staff member of the Lutheran and Methodist Hospitals, an associate on St. Joseph's Hospital staff, a certified specialist and diplomate of the American Board of Otolaryngology. Doctor Estlick was associated with Dr. Sanford C. Snyderman. He was a fellow of the American College of Surgeons, American Academy of Ophthalmology and Otolaryngology, Indiana Academy of Ophthalmology and Otolaryngology, International Congress of Otolaryngology, the Fort Wayne Academy of Medicine, Allen County Medical Society, Indiana State and American Medical Associations.

Harold B. Cox, M.D., Indianapolis physician for 40 years, died at his Indianapolis home on or about March 18. Doctor Cox, who had been in ill health which had caused curtailment of his practice, was found dead in his garage. Born in 1884, Doctor Cox was a graduate of Indiana University School of Medicine in 1910. He specialized in obstetrics.

Chandler Preston Runyon, M.D., 80, retired Elwood physician, died March 28 in his home following a long illness. A native of Mt. Meridian, Doctor Runyon was a 1900 graduate of the Indiana Eclectic Medical College, Indianapolis. He had practiced in Elwood for many years and also was in practice in Piedmont, California for several years. He was a former member of the Indiana and California State Medical Associations and of the American Medical Association.

Deckard L. Perrin, M.D., 83, who was a practicing physician for 50 years, died on April 6 in a Madison hospital after several years' illness. A native of Scott county, Doctor Perrin was a graduate of the Hospital College of Medicine in Louisville in 1898 and established his practice in Seymour shortly afterward. He was a member of the Indiana State Medical Association for many years.

Joseph B. Cox, M.D., 74, Evansville, died March 27 at Deaconess Hospital, Evansville. A native of Vanderburgh county, Doctor Cox was graduated from Louisville Medical College in 1901. During World War I he served as a flight surgeon and after discharge was with the Veterans Hospital in Louisville until his retirement in 1936.

Robert Frederick Buehl, M.D., former Indianapolis physician, died April 11 in the Veterans' Administration Hospital in Bay Pines, Florida. He had gone to Dunedin, Florida, for residence upon retirement last June. Doctor Buehl, who was 60 years old, was a graduate of Indiana University School of Medicine in 1918, a Navy veteran of World War I and served as a member of Indianapolis Selective Service Board during World War II. He was a former member of the staffs of Methodist and St. Francis Hospitals, Indianapolis, and had served as psychiatrist for several state institutions in both Indiana and Arizona. He was a former member of Indianapolis Medical Society, Indiana State and American Medical Associations.

Medical Class of 1903 to Celebrate Golden Jubilee at May 17 Meeting

Members of the class of 1903 of the Medical College of Indiana will meet at 11 o'clock Sunday morning, May 17, in Riley Hospital, Indianapolis, to celebrate the fiftieth anniversary of their class.

Dinner will be served at 12 o'clock promptly. A class meeting will follow and the afternoon will be concluded with a tour of the group of hospital buildings.

"This golden jubilee is the crowning point of our long career in the art of healing," Dr. Harry J. Weil, Indianapolis, said in announcing plans for the May 17 reunion.

News Notes

Indiana Doctors Furnished Request Forms for Gamma Globulin Prophylaxis Against Measles, Hepatitis

Distribution forms for 13,600 cc of gamma globulin allotted to Indiana by the Office of Defense Mobilization for prophylaxis against measles and infectious hepatitis are being forwarded by the Indiana State Board of Health to Indiana physicians.

This distribution is in keeping with the criteria established at a joint meeting of the Committee on Infantile Paralysis of the Indiana State Medical Association, members of the staff of the Indiana University School of Medicine and Hospitals, representatives of the Indiana State Health Officers Association and members of the Indiana State Board of Health, according to Dr. Albert L. Marshall, Jr., director, Division of Communicable Diseases, Indiana State Board of Health, through which the distribution is made.

Dr. Marshall pointed out that the allotment is made to each state on the basis of the reported cases of measles and poliomyelitis from 1947 through 1951. This allotment is packaged in 2 cc ampules and is not manufactured from large pooled sources of blood so is not recommended for prophylaxis against poliomyelitis. No official word of Indiana's allotment for prophylaxis against poliomyelitis has been received.

The cooperation of the physician in requesting the limited gamma globulin for measles prophylaxis is asked by Dr. Marshall in advising that it is available for any child from six months to four years of age; debilitated children; any child of any age known to have had tuberculosis, and for pregnant women who have not had measles but have been exposed to three day measles.

Gamma globulin for infectious hepatitis will be furnished only if the physician agrees to complete epidemiological forms as to the effectiveness of its use on contacts. It is limited to persons with intimate contacts either familial, institutional or for attendants closely associated with care of patients. All primary cases must be reported by name, age, sex, address and date of onset.

Final 1953 Psychosomatic Forum Meeting June 2

"Experiences in the development of a psychosomatic service at a Veterans' hospital" will be the subject of the discussion at the final meeting of the 1952-53 series of Psychosomatic Forums to be held at 8 p.m. June 2 in the sixth floor Conference room at the Veterans' hospital. Those presenting the discussion will be Dr. Frank W. Countryman, psychiatry, and Dr. James S. Browning, internal medicine. The Psychosomatic Forum is an organization of M.D.'s of all types who are interested in the role of emotions in disease. The four programs of the current series were designed to be of practical help in their practice.

Dr. Philip B. Reed, Norway's Foundation hospital, Indianapolis, who is president of the Central Neuropsychiatric Hospital Association, presided at the recent annual meeting of that organization in the Palmer House, Chicago. Doctor Reed spoke to the Milwaukee Neuropsychiatric Society on March 18 discussing "Some Medico-Legal Aspects of Electroshock." Several other members of Norway's staff participated in the Chicago program.

Doctors Help Support Medical Schools AMA Reports

Nearly 37,000 physicians contributed more than \$3,150,000 in direct support of medical education last year. This total, however, does not include amounts given for buildings, endowments, scholarships, research and other special purposes. Dr. Donald G. Anderson, secretary of the AMA's Council on Medical Education and Hospitals, announced that reports from 76 of the country's 79 medical schools indicate that more than 29,000 doctors gave \$2,258,534 directly for teaching budgets.

The American Medical Education Foundation raised \$906,553 of the total from more than 7,000 individual contributors. The AMEF's 1953 fund-raising drive has been launched with a third gift of \$500,000 from the AMA. Since its organization two years ago, the Foundation has raised more than two million dollars from the medical profession for distribution "without strings attached" to medical schools.

Dr. Joseph N. Bonner, who is associated with Dr. Arnold H. Duenling in the department of general surgery at the Duenling Clinic, Fort Wayne, has passed the examinations and been declared a diplomate of the American Board of Surgery, the Fort Wayne Medical Society has announced.

Pittsburgh Anesthesiology Symposium Announced

Full details of a Postgraduate Symposium on the Basic Sciences Related to Anesthesiology to be held in Pittsburgh June 8-12 may be obtained from the Chairman of the Committee on Graduate Medical Education, University of Pittsburgh School of Medicine, 3941 O'Hara Street, Pittsburgh 13, Pennsylvania. Cooperating with the university on arrangements are the Departments of Anesthesiology of the St. Francis, Allegheny General, and Mercy Medical Center hospitals. The course will be limited to 50 persons and a registration fee of \$25.00 charged. Among authorities who will present papers at the five-day symposium is Dr. George J. Thomas, who was a speaker at the 1952 Annual session of the Indiana State Medical Association.

Dr. Robert W. Currie has opened private offices in the Glass Block building, Marion, for the specialty practice of diagnostic and therapeutic radiology. Doctor Currie has served as radiologist at Marion Veterans' hospital for the last three years and is radiologist for Mercy hospital, Elwood. He is a 1935 graduate of the I. U. School of Medicine, interned at Methodist hospital, Indianapolis, and served a two year residency in internal medicine at Henry Ford hospital, Detroit, returning to Indianapolis for an additional year's residency in pathology. Doctor Currie was with Billings Clinic, Billings, Montana, before serving four years in World War II. Since his return, he has taken work in radiology at Lafayette, special radiological cancer training at Memorial Cancer Center, New York and served as head of radiology department at St. Elizabeth hospital, Lafayette.

He is a fellow of American College of Physicians, a diplomate of the American Board of Radiology, member of American College of Radiology and the Radiological Society of North America.

All physicians are invited to attend the Fifth Annual Convention of the **International Academy of Proctology** to be held at the Plaza Hotel, New York City, May 29, 30 and 31, 1953, directly preceding the American Medical Association Meeting. The meeting this year will be extended to include a Surgical Clinic and Seminar at Jersey City Medical Center under the direction of Dr. Earl J. Halligan. The "Wet Clinic" and Seminar will be on May 28. An extensive Motion Picture Seminar of Proctologic Surgery (including office techniques) will be held on May 31. All scientific papers will present the latest developments in proctology and gastroenterology.

There is no fee for attendance. The full program is available upon request from the Executive Offices of the International Academy of Proctology, 43-55 Kissena Blvd., Flushing, New York.

Eight Indiana Doctors Named to State Boards

Appointments to the medical advisory committee authorized in Senate Bill 205 which was passed by the 1953 Indiana General Assembly have been completed by Governor George N. Craig. The committee, a part of the newly created Department of Health, will be composed of the following members:

Dr. Dillon Geiger, Bloomington ear, nose and throat specialist who was named chairman at the first meeting of the committee.

Dr. Margaret E. Morgan, Austin, who is on the Indiana University School of Medicine psychiatry staff.

Dr. William H. Howard, Hammond surgeon and president-elect of the Indiana State Medical Association.

Dr. E. Vernon Hahn, Indianapolis, psychiatrist and neuro-surgeon.

Dr. Bert E. Ellis, Indianapolis, clinical professor of otolaryngology at Indiana University School of Medicine.

Three appointments have also been made to the Indiana State Board of Health. These selections made by Governor Craig are:

Dr. Arnold H. Duemling, Fort Wayne, surgeon and head of the Duemling Clinic, Fort Wayne.

Dr. William A. Karsell, Bloomington specialist in obstetrics and gynecology.

Dr. David L. Adler, Columbus, clinical pathologist.

Chest Physicians to Meet in New York May 28

Among participants in the program arranged for the four-day 19th Annual Meeting of the **American College of Chest Physicians** will be Dr. John V. Thompson, Indianapolis, who will be one of a five-member panel discussing "Management of Bronchiectasis" on May 29. Sessions will be held in the Hotel New Yorker from May 28 through May 31. An outstanding program has been arranged for the scientific seminars under the chairmanship of Dr. Arthur M. Olsen, Mayo Clinic, Rochester, Minnesota. Among the guest speakers from other countries who will participate in the program are Sir Alexander Fleming and Dr. Richard R. Trail, both of London, England.

Dr. Richard G. Mehne, formerly of Indianapolis, has begun the practice of general medicine in Brazil, occupying the offices of the late Dr. C. C. Sourwine. Doctor Mehne, a graduate of Butler university, received his M.D. degree from Northwestern university in 1951, interned at Cooke County hospital, Chicago, and then was associated for a short time with the Drake Clinic in West Virginia. He is a World War II veteran.

Dayton Polio Symposium Scheduled for May 26-27

Clinical demonstrations will be presented on May 26, opening day of the Miami Valley Symposium on Poliomyelitis, in the Miami Valley Hospital, 134 Apple Street, Dayton, Ohio between 1:30 and 4 p.m. The Miami Valley School of Nursing in cooperation with the Montgomery County Chapter American Red Cross and Polio Foundation will be in charge with Dr. Herman J. Bearzy, director of the hospital's Department of Physical Medicine and Rehabilitation, serving as moderator. Demonstrations will include nursing procedures in all stages of polio, use of special equipment in treatment, physical and occupational therapy procedures, bracing procedures and a color film. A luncheon at 12:15 at the Biltmore Hotel, Dayton will precede the symposium. Reservations should be made with Mrs. Frances Swygert, Fidelity Building, Dayton, Ohio.

On May 27 at 1:30 p.m. Doctor Bearzy will again moderate a program to be presented in the Biltmore Hotel. Speakers will include Warren E. Wheeler, M.D., professor of pediatrics, Ohio State University, Columbus; Gordon M. Martin, M.D., Mayo Clinic, Rochester, Minnesota; Kenneth D. Arn, M.D., internist, Dayton; and Hart E. Van Riper, M.D., medical director of The National Foundation for Infantile Paralysis, New York.

A question and answer period will conclude the symposium.

Meeting of Liaison Committee Reported

Third meeting of the Liaison Committee of the American Legion, Indiana State Medical Association, Indiana State Dental Association and the Indiana Hospital Association.

Sunday, March 15, 1953.

Those present:

Indiana Dental Association—

Dr. G. T. Gregory

Indiana State Medical Association—

Dr. Jack Shields,

Dr. Maurice Glock

Veteran's Administration—

Dr. A. E. Trollinger, Manager,

Marion V. A Hospital

Dr. S. T. Ginsberg, Chief of Professional
Services, Marion V. A.

Indiana Hospital Association—

Mr. Alvan A. Sauer,

212 Napoleon Blvd., South Bend,

Superintendent, Northern Indiana

Children's Hospital

American Legion—

Judge Frank Russell

Mr. William O'Neill

Dr. Norman R. Booher

Mr. Paul V. Shrader

Mr. Frank J. Myers

Mr. Nicholas Lynch

Minutes of January 18, 1953 meeting read and approved.

Doctor Gregory presided with Indiana Dental Association as host.

Doctor Booher reported on National Liaison Committee meeting in Washington, March 1 and on action of American Legion in setting up Liaison Committees. He also presented copies of H.R. 2862 on Federal Board of Hospitalization.

Chairman Gregory introduced subject of dumping of compensation and accident cases in V.A. hospitals. Shrader discussed situation first. Pointed out that accident cases are sometimes brought in and pointed out the big problem of drunks. Problem of alcoholism widely discussed.

Doctor Ginsberg discussed relation of service connected N.P. cases and alcoholism as an aggravation. Further discussion followed on the dumping of cases without legal entitlement in V.A. hospitals. Committee felt P.L. 312 should be followed strictly in this matter by veterans, doctors, dentists and hospital administrators and that all concerned should educate their members accordingly.

Doctor Glock moved that this committee recommend through the National Liaison Committee, that the Administrator of V.A. be requested to put into use a form 10P10 for admission to V.A. hospitals which will allow non-service-connected cases who enter V.A. hospitals and can afford to pay for their care, to be investigated and prosecuted for fraud; and it is recommended that the oath of the 10P10 include a forfeiture clause similar to that used on other V.A. benefits; and also provision for an investigation by the V.A. be provided for in all cases upon which a sworn complaint is received by the V.A. from any citizen. Seconded by Judge Russell. Passed unanimously.

Next meeting set for Sunday, May 17, as guests of Indiana State Hospital Association.

Doctor Booher moved committee approve H. R. 2862. Seconded by Doctor Glock. Passed.

Doctor Booher moved that we approve a joint survey of Indiana V.A. Hospitals, except Marion, of all non-service-connected G.M.&S. cases as per procedure approved by all organizations concerned, with help of personnel of American Legion Field Service and such other personnel as other organizations can provide. Seconded by Judge Russell. Passed.

Doctor Trollinger discussed general subject of mechanism of admissions to V.A. hospitals, especially as applied to his Marion, Indiana, hospital. Doctor Ginsberg estimates there are 2,000 veterans in Indiana who should be in a mental hospital and there are about 200 veterans in Indiana who need mental hospital care and no bed is available, and Marion has 180 non-service-connected on waiting list. General discussion of mental hospital facilities in V.A. and State of Indiana followed.

Doctor Booher read excerpts from Annual Report of Administration of V.A. for 1952 on breakdown of all cases in V.A. in 1952.

It was decided that agenda for next meeting would include the following items:

1. Discuss details of survey of Indiana V.A. Hospitals.
2. Invite representatives of A.H.A. to attend and discuss with us projection of necessary V.A. beds in Indiana and other problems of hospital construction and facilities.
3. Doctor Glock authorized to invite Doctor Ferguson of Fort Wayne to present his views, with Central Office of V.A. to be requested to send a representative to present any other side of picture under discussion.

Meeting adjourned after dinner at 7:30 p.m.

Two Area Cancer Society Meetings Held

Area meetings of the Indiana Division, American Cancer Society were held in Bloomington on March 18 and in New Castle on March 23. Both meetings were leadership training conferences. Mrs. Lucy R. Milligan, director of volunteer training and recruitment of the American Cancer Society, New York, spoke at both sessions. Indiana doctors who participated in the conferences were Dr. Okla W. Sicks, Indianapolis, who spoke on the "Importance of Early Diagnosis of Cancer" which he illustrated with colored slides; Dr. Philip T. Holland, Bloomington; Dr. Anthony Pizzo, Bloomington, who reported on "Pathological Services, Monroe County Hospital"; Dean John D. Van Nuys, Indiana University School of Medicine, "Cancer Research" and Dr. W. U. Kennedy, New Castle.

The **First Annual Essay Award** sponsored by the American Congress of Physical Medicine and Rehabilitation has been announced by the Chicago headquarters at 30 North Michigan Avenue, Chicago 2. The contest is open primarily to medical students, interns, residents and graduate students and the essay may be on any topic pertaining to the field of physical medicine and rehabilitation. Manuscripts, in duplicate and not to exceed 5,000 words, should be mailed to

American Congress of Physical Medicine and Rehabilitation at the above address. The winner will receive a gold medal, a certificate of award and an invitation to present the contribution at the 31st Annual Session of the Congress at the Palmer House, Chicago, August 31 through September 4, 1953.

A.M.A. Inaugural Ceremony Will Be Broadcast by ABC

The American Broadcasting Company radio network will carry the inauguration of Dr. Edward J. McCormick of Toledo, Ohio, as President of the American Medical Association on Wednesday night, June 3, it has been announced by A.M.A. headquarters in Chicago.

The inaugural ceremony at the 102nd Annual Session of the A.M.A. in New York City will be heard over more than 300 ABC stations in this country, Alaska and Hawaii. Except for some local variations because of station program schedules, the inauguration will be carried at 10-10:30 P.M. in the Eastern Time Zone and 9-9:30 P.M. in all other time zones.

The actual inaugural ceremony will take place Tuesday night, June 2, in the Hotel Commodore, but it is expected that practically all radio and television time that night will be disrupted by special news and film programs on the coronation of Queen Elizabeth. It therefore will be necessary to transcribe the program for a delayed broadcast on Wednesday night.

Evansville Plans Tri-State PG Assembly

Members of Vanderburgh County Medical Society have mailed announcement of their second annual Post-Graduate Assembly to be held in Evansville on May 14 to all physicians in the Tri-State area. The day long meeting is scheduled to be held in the Hotel McCurdy.

Hospital clinical sessions, a series of panel discussions and exhibits by several pharmaceutical houses have been arranged. Dr. Arthur Griep, Post-Graduate Committee chairman, has obtained outstanding speakers for the afternoon roundup session and for the dinner.

A.M.A. WASHINGTON OFFICE NEWS

Mrs. Hobby, Budget Director, AMA Witnesses Heard by Committee. Senate and House Committees on Government Operations, meeting jointly, devoted one long day's sessions to President Eisenhower's plan for creating a Department of Health, Education and Welfare. Principal witnesses were Joseph M. Dodge, director of the Bureau of the Budget; Mrs. Oveta Culp Hobby, the present Federal Security Administrator who would become Secretary of the new Department, and three witnesses for AMA, former Presidents John Cline and Elmer Henderson, and Dr. Dwight Murray, chairman of the Board of Trustees.

Efficiency of Operation. Mrs. Hobby and Mr. Dodge explained that while there would be an initial investment in the new department, the long-range effect should be a stronger, better controlled operation, with resulting economies. Mr. Dodge said the extra cost in salaries, \$32,500, would be absorbed in the revised FSA budget to be presented to Congress. Mrs. Hobby: "Before we can have good plans, my business experience has shown me that we must make a small investment." Mr. Dodge said the plan carried out the accepted business practice of creating positions of authority, then filling them with capable people.

Differences in this and Earlier Reorganization Plans. Twice Congress rejected Truman plans for a three-way department. Democratic members of the joint committee argued that there wasn't much difference between them and the 1953 plan. However, Mr. Dodge said that while this plan is similar to the 1950 plan, it is basically different from the 1949 plan. Furthermore, he, Mrs. Hobby and the AMA spokesman emphasized that the top level position of Special Assistant to the Secretary (for Health and Medical Matters) was not contained in any other plan ever submitted to Congress.

Special Assistant for Medical Matters. Senator Humphreys and several other committee members wondered if the post of Special Assistant to the Secretary for Health and Medical Matters wasn't a concession to the medical profession, and particularly to AMA. Dr. Henderson said this official would be able to guard against socialized medicine by "making recommendations to the Secretary." Rep. Judd: "This position was created so the people who have provided the best medical care in the world will be able to continue to provide the best medical care in the world." Mrs. Hobby explained that the Special Assistant would advise her, but that he wouldn't have any administrative authority over the Surgeon General of Public Health Service.

Replacement of Hold Over Personnel. Mrs. Hobby said the Department status would help in getting people sympathetic with her views in the key jobs, but that she might need more authority. Mr. Dodge promised that legislation on this subject would be introduced shortly. Mrs. Hobby explained that the Civil Service Commission was considering giving her appointive authority over more policy-making jobs. She estimated it would take not less than six months to get her "team on the field."

Gamma Globulin Distribution Plans Announced by ODM. Office of Defense Mobilization has worked out basic policy for distribution to the States of gamma globulin under *non-epidemic* poliomyelitis conditions. Before April 15, ODM hopes to have the final word on distribution policy under *epidemic* situations. Two questions to be answered are (a) what constitutes an epidemic? and (b) what portion of the population will get inoculations in epidemic areas?

On basic policy, ODM has decided on the following and so notified all state and territorial health officers:

(1) Around May 1 each state, on request of its state health officer, will receive an *initial allocation* based on 40 cc times the median number of reported cases in that state for the 5-year period ending in 1951.

(2) *Total basic allotment* for the year will be determined for each state on the basis of 40 cc times the number of *reported clinically diagnosed* cases during the current year.

(3) State health officers will make available to individual physicians sufficient gamma globulin to give inoculations to patients who have had intimate contact with clinically diagnosed cases. *ODM is leaving up to the individual physician the determination of what is intimate contact.*

The remaining major part of gamma globulin for polio will be kept in a national pool to be sent to epidemic areas when the need arises. ODM estimates total national supply of gamma globulin for polio this year at between 6 and 7 million cc. Another 2 million cc is being earmarked for measles and infectious hepatitis. ODM said the American Red Cross was packaging the serum for polio in 10 cc vials which will be marked "Poliomyelitis Immune Globulin."

One-Man Office Replaces Medical Policy Council. The six-man Armed Forces Medical Policy Council will be abolished on April 1 and its chairman for the past year, Dr. Melvin A. Casberg, will become an assistant to the Secretary of Defense with responsibility for all health and medical affairs in the Defense establishment. Dr. Casberg, former dean of St. Louis University School of Medicine, reports directly to Secretary of Defense Charles E. Wilson and is responsible to him.

Dr. Casberg will be advised by a six-man Civilian Health and Medical Advisory Council which, unlike the old policy council, will have *no representation from the Army, Navy or Air Force*. Reappointed from that council are Drs. Isidor S. Ravdin and Alfred R. Shands, Jr., and James P. Hollers, DDS. Serving with them will be Drs. William S. Middleton, University of Wisconsin; Dwight L. Wilbur, Stanford University; and Anthony J. J. Rourke, president, Hospital Council of Greater New York.

The new assistant to the Secretary will have responsibilities similar to those of the Council in advising on the number of physicians to be called each month under the doctor-draft law.

Strauss Commission Recommends Limiting Special Pay. Congress has before it a strong recommendation to stop the special \$100 per month pay to physicians and dentists who serve only the minimum time required under the Doctor Draft law. The recommendations come from a special five-man Defense Department-appointed commission which has been looking into military differential pay. The report also recommends elimination of extra pay for sea duty and foreign duty, and of flight pay for certain officers. The study was made at the suggestion of the Senate Armed Services Committee.

The Commission was headed by *Lewis L. Strauss*, former Atomic Energy Commission member and now special assistant to President Eisenhower on atomic energy matters. The Commission reasoned that although the special pay has merit as an "encouragement to physicians and dentists to enter the services as a career," and that it has "alleviated in part the critical shortage of military physicians," it has not met the full need. As an incentive to volunteer for limited periods of duty, the Commission found that the special pay "does not appear to be required." The report concludes that the extra \$100 per month should not be given to physicians who serve no longer than other citizens are required to serve in uniform.

The specific recommendation is "That special pay for physicians and dentists be limited to regular officers, and to reserve officers who volunteer and are accepted for extended active duty beyond that required by Public Law 779 or subsequent similar legislation."

Because of multiple manpower regulations of the Defense Department and of the three services, and laws laid down by Congress, it is impossible now to obtain a clear interpretation that answers all possible questions as to what the Commission might mean in specific cases. However, a spokesman for Defense Department said this much is certain:

1. The Commission *does not believe* that physicians coming into service for two years, under compulsion, should receive the extra pay.
2. It *does believe* that those who genuinely volunteer for more than the required time should be given the extra pay. (The Commission made no effort to set a minimum time for qualification for the extra pay, leaving this to Congress and the three services.)
3. Those who qualify for the special pay should receive it *from the beginning* of their active duty.

Eliminating the special pay for those physicians and dentists performing only the two years of required active duty would, the Commission estimates, save the government \$14.5 million a year. Without action by Congress, the special pay provision will expire June 30, 1953. The Senate and House Armed Services Committees, which must consider the Doctor Draft law extension, also would act on the special pay issues.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

March 29, 1953

Roll call showed the following present: W. L. Porteus, M.D., chairman; James W. Denny, M.D.; W. H. Howard, M.D.; E. R. Clarke, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; James A. Waggener, executive secretary; Robert J. Amick and Bruce G. Nowlin, field secretaries.

Membership Report

Number of members March 25, 1953	-----3,343*
Number of members March 25, 1952	-----3,365
Loss over last year	-----22
Number of members December 31, 1952	-----3,779

* Includes 120 in military service (gratis)
 72—\$10.00 members (residents and interns)
 214—senior members
 57—members, dues remitted by Council

Number who have paid AMA dues:
 1952-----3,244; 1953-----2,809

Headquarters Office

The field secretaries, Mr. Amick and Mr. Nowlin, reported on their activities during the past month, and attention was called to the increase in number of society meetings to which dentists are invited. It was the recommendation of the Executive Committee that the field secretaries call this to the attention of the societies within their territories, pointing out what is being done by other societies and recommending consideration of such meetings as a good public relations movement.

The committee also suggested to the field secretaries that they compile a card list of members of the legislature, listing all information they can obtain on each, and continue their acquaintance with these men during the interim between sessions of the state legislature.

It was also suggested by the committee that the field secretaries might suggest combining county medical societies for meeting purposes.

Statements of receipts and expenditures and report on the budget for January and February for the Association and THE JOURNAL were approved.

Legislative Matters

National—The Executive Secretary reported on the March 14 special meeting of the House of Delegates of the American Medical Association, held in Washington, D. C., and on the National Health Council meeting, held in New York on March 18 and 19.

Local—The Executive Secretary reported on the activities and legislation handled in the recent session of the state legislature.

Organization Matters

Vice-president and speaker of House of Delegates. Upon motion of Drs. Denny and Clarke, the committee voted to suggest to the Council that consideration be given to the establishment of a vice-presidency in the association or a speaker of the House of Delegates, or both. In making this suggestion it was the thinking of the committee that the establishment of these offices might relieve the president of some of the demands made upon him, in view of the expanding field of activities of the association.

Request of the Press Club for an ad in its Grid-iron program, in the amount of \$75.00, was turned down by consent.

Letter from Mrs. Hubert T. Goodman, president of the Woman's Auxiliary, outlining the financial situation of the Auxiliary and requesting a subsidy in the amount of \$400.00 from the association for the 1953-54 year, was read, and upon motion of Dr. Howard, seconded by Dr. Clarke, the sum of \$100.00 was allowed.

Letter from Theodore C. Jarvi, of Hartford, Connecticut, seeking permission of the association to include Indiana in a study of a pension and insurance benefit plan for physicians was read, and turned down by the committee.

Locations for scholarship students. The committee, by consent, ruled that the last known Committee on Medical and Nursing School Scholarships should have the first opportunity of designating locations for scholarship students.

The secretary informed the committee that, in view of the situation confronting the association for the proposed 1954 meeting at Fort Wayne, the dates of October 26, 27 and 28, 1954, had been reserved at the Murat Temple, Indianapolis, in case the Council decides to hold the meeting in Indianapolis rather than in Fort Wayne.

Resolution from the West Virginia State Medical Association relative to the use of medical personnel by the armed services was acknowledged.

The secretary reported that the president has requested by phone that the matter of endorsement of the World Medical Association should be discussed by the committee and that it was his feeling that the Association as such should not endorse this organization any more than they would any other organization, and that it should

be made clear that members were free to join or not to join this organization as they saw fit. This recommendation of the president was accepted by consent.

The Journal

Report on advertising was approved by consent:

Total, March, 1952 -----\$2,094.11

Total, March, 1953 -----\$1,858.24

Future Meetings

Attention was called to the invitation of the Indiana State Chamber of Commerce for the association to be represented at the annual meeting to be held in French Lick April 10, 11 and 12, 1953, and the committee instructed the president, or the secretary, or both, to attend this meeting.

The next meeting of the Executive Committee was set for 4 p.m., Saturday, April 25, at the Columbia Club.

LOCAL SOCIETY REPORTS

Dr. Herbert J. Karol, Fort Wayne, presented a paper on "Genitourinary Problems in General Practice" before 10 members of the **Adams County Medical Society** at the March 9 meeting held in Decatur. At the February 9 meeting Dr. R. K. Parrish, Decatur, gave a special report on papers which were presented at the ACS meeting at Cincinnati.

DeKalb County Medical Society met March 10 at 9:15 p.m. in Sanders hospital, Auburn, to hear a paper by Dr. A. V. Hines, Auburn, on "Total versus Subtotal Hysterectomy". Nine members attended and at a brief business meeting cast a vote expressing satisfaction with operation of the present draft law in DeKalb county. The action was in reply to a circularized resolution from Erie County, New York, regarding draft law revision.

Forty-five members of **Elkhart County Medical Society** met March 5 in the Hotel Elkhart for a dinner meeting at which Mitchell J. Nechtow, M.D., Chicago, was the guest speaker. His topic was "Practical Office Gynecology". On April 2 at the regular monthly meeting in Hotel Elkhart Dr. William J. Baker, associate professor of

urology at the University of Illinois, spoke on "Present Day Management of Urinary Obstructions."

Tippecanoe County Medical Society held a business meeting on March 10 in Lincoln Lodge, Lafayette. Forty members attended the combined dinner and business meeting.

David L. Adler, M.D., Columbus, spoke on "Experiences in Pathology" at a dinner meeting of the **Wayne-Union County Medical Society** in the Leland Hotel, Richmond. Thirty-two members attended the March 19 meeting.

The **Northeastern Academy of Medicine** met on March 26 in the Publix cafe, Kendallville, with members of the auxiliary and office assistants as special guests.

Mr. Albert Stump, Indianapolis, legal consultant for the Indiana State Medical Association, was the speaker. His subject was "Truth and Freedom." Dr. James A. Alford, secretary of the Northeastern Academy, reported that the talk was extremely interesting with members and guests making many favorable comments.

The secretary also reported that 57 persons attended the March meeting adding that the academy had been very active during the year, presenting a scientific program each month from September to April inclusive.

Bruce Nowlin, new field secretary for the northern part of the state, attended the March meeting, speaking briefly to express his desire to be of service to the Northeastern Academy and other medical groups in the area.

Wire recordings on ACTH and Cortisone were heard by 13 members of the **Putnam County Medical Society** at their April 10 meeting in the DePauw Memorial Union building, Greencastle. The program followed a 6:30 o'clock dinner meeting. The next program was scheduled for May 8.

Dr. Francis C. Guthrie, who has retired after 32 years of practice in Anderson, was the guest of honor at the **Madison County Medical Society** in the Anderson Country Club February 16. Dr. and Mrs. Guthrie have gone to Vero Beach, Florida to make their future home. Dr. Seth Ellis, president of the society, was in charge of the meeting and Dr. R. S. McQuiston, Indianapolis, was the speaker. Members presented Doctor Guthrie with a motion picture camera and projector as a farewell gift.

Dr. Robert Lich, Jr., clinical professor and chairman of the section on urology, University of Louisville School of Medicine, Louisville, was the guest speaker of the **Orange County Medical Society** on April 7 in the French Lick Springs Hotel. Eight members and one guest heard his paper on "The Practitioner as a Urologist."

Vanderburgh County Medical Society members held a regular meeting April 14 in the Hotel McCurdy at which time they heard a scientific paper by Edwin G. Eigel, M.D., St. Louis, who spoke on "Early Diagnosis of Poliomyelitis and Problems Arising in the Care of the Poliomyelitis Patient". Doctor Eigel is chief physician of St. Anthony's Hospital poliomyelitis unit for eastern Missouri, president of the St. Louis Pediatric Society and assistant clinical professor of pediatrics at St. Louis University Medical School.

Dr. Harry W. Southwick who is associated with the cancer program being conducted by the University of Illinois was the speaker at the March 26 meeting of **Grant County Medical Society** held jointly with the Grant County Cancer Society. Subject of Doctor Southwick's address was "Recent Advances in the Treatment of Cancer" in which he discussed advanced surgical techniques, variations in radiation therapy



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and the chemotherapeutic approach to malignant disease. The meeting was held in Emley's restaurant, Marion.

Thirteen members of **Boone County Medical Society** met April 7 in Witham Memorial Hospital, Lebanon, to hear one of a series of telephone seminars which the society has been employing regularly as program material.

Dr. Chester A. Stayton, Jr., Indianapolis, discussed "Difficulties in Gastro-Intestinal X-Ray" before the April 7 dinner meeting of the **Howard County Medical Society**. Twenty-eight members attended. A business meeting followed the presentation of the paper by the guest speaker.

Floyd County Medical Society members discussed activities in connection with the new hospital now nearing completion and by-laws governing the staff membership at a 5 p.m. meeting held on March 13 in the New Albany Country Club. Nineteen members participated in the round table discussion.

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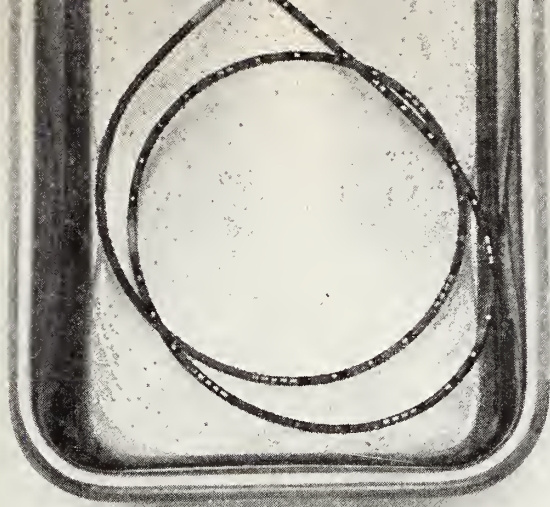
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Official programs for the Thirtieth Annual Meeting of the Woman's Auxiliary to the American Medical Association have been received from Margaret N. Wolfe, executive secretary. The convention will be held simultaneously with the 102nd Annual Session of A.M.A. Headquarters will be at Hotel Statler, New York, with registration beginning at noon on Sunday, June 1 and continuing each morning through June 5. All members of the Auxiliary, their guests, and the guests of physicians attending the convention are invited to attend general meetings and participate in all social functions of the Auxiliary.

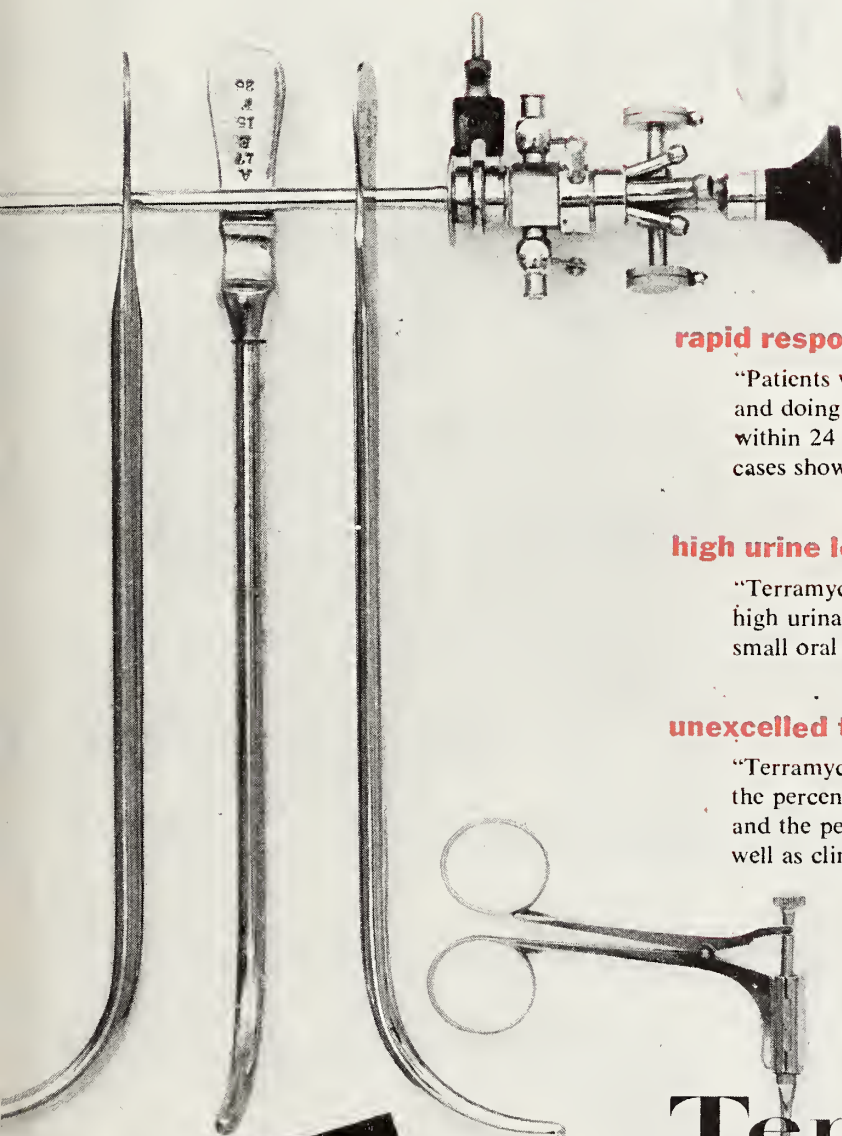
Highlighting the program will be the address by the president, Mrs. Ralph B. Eusden, on Tuesday, June 2; an address by Dr. Kenneth McFarland, educational director, American Trucking Association, Inc., June 2; the inaugural address of the incoming president, Mrs. Leo J. Schaefer, June 4; an address by Mrs. Ivy B. Priest, Treasurer of the United States, at the annual dinner for husbands, members and guests at the Hotel Waldorf-Astoria on June 4.

All members of the Woman's Auxiliary and guests are also invited to attend the reception and ball in honor of the President of the American Medical Association in the Hotel Commodore on Tuesday evening, June 2.

Report of the Indiana Auxiliary will be presented at the afternoon session on June 2.



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1. Canad. M. A. J. 66:151 (Feb.) 1952.
2. J. Urol. 67:762 (May) 1952.
3. Ibid. 69:315 (Feb.) 1953.



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Efficacy of Ammoniated Dentifrices Questioned

Ammoniated dentifrices have failed to live up to their promise and have no special value in reducing tooth decay, it was reported recently in *The Journal of the American Dental Association*.

The report was based on extensive research studies made by Dr. B. G. Bibby, director of the Eastman Dental Dispensary at Rochester, N. Y., and Lt. R. R. Hawes, of the Air Force Dental Corps at Randolph Air Force Base, Texas.

"There is no satisfactory evidence—notwithstanding the advertising claims—that a dentifrice with a high urea content reduces dental decay," they said.

Ammoniated dentifrices are tooth pastes and powders containing the ingredient urea to which the compound dibasic ammonium phosphate is usually added.

To evaluate the effectiveness of ammoniated dentifrices, the dental scientists conducted a one-year clinical and bacteriological study among school children between the ages of seven and 13.

In the clinical study, an experimental group of 196 children brushed their teeth with an ammoniated dentifrice while 176 children served as a control group and brushed their teeth with a neutral or cosmetic dentifrice. Neutral or cosmetic dentifrices are those with conventional cleansing properties.

All the children were instructed in a proper toothbrushing technic, which was carried out under supervision at the beginning of each school day and independently at home in the evening.

The investigators found that during the test

period, the children who used the ammoniated dentifrice were found to develop tooth decay at approximately the same rate as those who used the non-ammoniated dentifrice.

Drs. Bibby and Hawes said that their studies indicated that ammoniated dentifrice had little effect on the presence of lactobacillus in saliva. A count of these bacteria in saliva has long been used to measure decay activity.

"No evidence was found that the use of the urea dentifrice altered the number of lactobacilli in the saliva to a greater extent than in the use of cosmetic dentifrices," the dental scientists said.

Similar findings were reported for a supplemental eight-week study of 75 young women dental hygiene students, also conducted by Drs. Bibby and Hawes. They concluded:

"The negative clinical observations and laboratory findings . . . offer adequate grounds for questioning the soundness of the concept that the ammonium ion dentifrices have any value in the prevention of dental decay." — American Dental Association.

A summer camp for diabetic children will be opened for the fifth season under the auspices of The Chicago Diabetes Association, Inc., from July 21, 1953 to August 10, 1953 at Holiday Home, Lake Geneva, Wisconsin. Applications may be obtained from, and inquiries should be addressed to: Service Unit, Chicago Diabetes Association, 110 South Dearborn Street, Chicago 3, Illinois.

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Books

BOOKS REVIEWED

DISEASES OF METABOLISM—Detailed Methods of Diagnosis and Treatment; Edited by Garfield G. Duncan, M.D., Director of Medical Division, Pennsylvania Hospital; Clinical Professor of Medicine, Jefferson Medical College, Philadelphia, Pennsylvania. New, 3rd Edition. 1179 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1952. Price \$15.00.

It is a pleasure to see this excellent text book in a new revision. The newly added contributors maintain the authority of the previous editions.

This reviewer has seen no substitute for this book in the fields covered. The individual subjects discussed are of monograph quality and as terse as the subject will allow.

This book can be heartily recommended for any physician handling patient's with metabolic disturbances.

S. L. J.

CLINICAL OBSTETRICS by Members of the Staff of the Pennsylvania Hospital, Edited by Clifford B. Lull, M.D., Late Director, Division of Obstetrics and Gynecology, Pennsylvania Hospital and Robert A. Kimbrough, M.D., Director of the Division of Obstetrics and Gynecology, Pennsylvania Hospital. Cloth. Price \$10.00. pp. 732 with 392 illustrations and 8 plates in color. J. B. Lippincott Company, Philadelphia, Pennsylvania, 1953.

The 20 co-authors of this new book in obstetrics are or have been members of the staff of the Pennsylvania Hospital. The editorship was originally undertaken by the late Clifford Bell Lull, M.D. After his untimely death, Robert A. Kimbrough, M.D. completed the volume.

The intent of the book is to record the current methods of management of the pregnant woman as practised at the Pennsylvania Hospital Division of Obstetrics and Gynecology. Since this institution is one of the oldest and important teaching hospitals in America, a unified presentation of the present day practices of this group is welcomed. Methods and techniques in roentgenology which have become increasingly valuable in the management of obstetric complications have been discussed. The special chapter based on the Nutritional Research Clinics' five year study, which has pointed out practical guides for prenatal care with a view of reducing the incidence of toxemia of pregnancy and prematurity, has been recorded in detail. Special effort is made in presenting the most recent material and practice in fields of sterility, hemolytic disease, obstetric-pediatric relationship and routine nursing procedures. The last chapter deals with the legal aspects in obstetric care.

Students will recognize the illustrations as having been carefully selected for their teaching value. The authors have used many of Peham and Amreich, Lull and Hingson, McNeile, Patten, Dickinson, Hertig and Rock, Zabriskie and Eastman, Siegler, Davis, and DeLee, as well as numerous new illustrations by the present authors. The illustrations in the section on obstetric roentgenology constitute an atlas in this field by Dr. Paul A. Bishop.

No attempt is made by the authors to make exhaustive references. At the end of each chapter, however, there are key references for those who wish to study further.

T. M. C.

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4.	Joseph M. Black, M.D., Seymour.....	Clifford A. Wiethoff, M.D., Seymour.....	Seymour, May 5, 1954
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Opinions From Here and There

Prepared for your information by the Committee on Public Policy and
Legislation of the Indiana State Medical Association

ECONOMISTS COME UP WITH SOME FIGURES worth studying. Speaking before an Indianapolis group of business and professional men, Mr. Carl H. Wilken, economic analyst for the Joint Committee on Defense, stated that the nation's wealth can always be measured at 7 times the farm income. He pointed out that if farm income decreased 5 billion dollars, the national income would decrease 35 billions of dollars. He also stated that studies covering several past decades, showed that the American family spent 21.8 per cent of income for food. This figure, he stated, even held during depression years.

FARM POPULATION HAS DECLINED 5,500,000 during the last 10 years according to figures released by the U. S. Bureau of the Census. Except for the fact that this figure is quoted it is not news as the farm population has been declining steadily since 1916, except for a brief rise around 1935. In fact the report says the farm population has been dropping ever since census figures on the subject appeared in 1820.

IS THE NATION'S FOOD SUPPLY THUS ENDANGERED? Looking at another set of figures, since 1936 the agricultural production total, per capita, and per farm worker, has been increasing steadily. The explanation can hardly be found in increased acreage as this has gone up but slightly.

MECHANIZATION AND MODERN METHODS HOLD ANSWER to the increased production. Farm trucks and tractors, for instance, have increased from under 100,000 in 1910 to 6,580,000 in 1952.

POSTGRADUATE EDUCATION EXPENSE MAY BE RULED as a valid expense deduction for physicians from their income tax as a result of the U. S. Appellate Court's reversal of the U. S. Tax Court verdict in a case filed by a lawyer claiming deduction of expense for attending a course on taxation was a valid expense deduction. The AMA is studying the verdict

closely and its relation to the profession. In attempting to get a favorable ruling from the government on this matter the AMA had filed a brief in the same case as *amicus curiae*. A complete analysis and its effect upon physicians will be published in an early issue of the JOURNAL of the AMA.

AMA MEMBERSHIP REPORTED AT 140,000 as of December 31, 1952. The report shows 126,000 active members; 9,000 service members (members in armed forces), Public Health Service and Veterans Administration; 5,000 associate members. It is recommended in quoting AMA membership figures that physicians use the 140,000 figure as some confusion exists in the public mind since figures have been quoted all the way from 120,000 to 160,000.

HOUSE PASSES DOCTOR DRAFT EXTENSION BILL by voice vote with no dissents heard. Explanations took three hours. Chairman Short of Armed Services Committee said: "If there is a more complicated subject I have never seen it." One change only made—amended to allow government-educated or World War II draft-deferred men to move from priority 2 to priority 4 if they had 17 months of active duty.

THREE MORE JOBS IN DEPARTMENT OF H.E. & W. (formerly FSA) removed from Civil Service protection. Director Hobby will now have free hand in appointing the Director of Bureau of Public Assistance; Chief of the Bureau of Old Age and Survivors Insurance, and Director of Vocational Rehabilitation.

DEFENSE DEPARTMENT WILL ADD AN ASSISTANT SECRETARY FOR HEALTH AND medical matters if Reorganization Plan 6, now before Congress is not rejected. The AMA has urged that such a post be set up, "in an effort to insure a more equitable utilization of medical manpower by the armed services." If not rejected the plan will go into effect about July 1.

FEDERAL OLD AGE AND SURVIVORS INSURANCE PROGRAM will be scrapped if Senator Frear (D-Del.) is successful in getting his bill passed by Congress. The bill proposes that in scrapping the plan that the OASI Trust Fund be turned over to the various states.

FEDERAL CIVILIAN EMPLOYMENT DROPPED TO LOWEST figure since June 1950 according to a report issued by Senator Byrd (D-Va.).

SENATOR TAFT INTRODUCES BILL TO GIVE FEDERAL INCORPORATION CHARTER to National Fund for Medical Education. The incorporators listed comprise a "Who's Who." Naming a few of the more than three

score are; Dr. Howard A. Rusk, Secretary of the new department of HEW, Oveta Culp Hobby, Bernard F. Gimbel, Eric A. Johnston, Alfred P. Sloan, Thomas J. Watson, Edward J. Noble, Owen J. Roberts, Winthrop Rockefeller, Gen. Lucius D. Clay, Dr. Frank H. Lahey, George W. Merck, S. Sloan Colt and Margaret Culkin Banning. On first Board of Trustees will be Herbert Hoover, Leroy A. Lincoln, Juan T. Trippe, Colby M. Chester and 10 others.

DOCTOR DRAFT BILL AS REPORTED FAVORABLY TO HOUSE embraces virtually all the major changes recommended by the National Veterans Medical Society. Some of the provisions are; Registrants who have had at least 12 months military service since 1940 shall be liable to serve no longer than 17 months; drops into priority IV those priority II's having at least 18 months service, exempts from further obligation for active duty those who have had 21 months or more of active duty subsequent to September 1940, provides that all physicians, dentists and veterinarians who have been inducted or involuntarily placed on active duty, but who would **NOT** have been had provisions of HR 4495 been in effect, shall be let out within 90 days following enactment of the bill.

SELECTIVE SERVICE RELEASES LATEST REGISTRANT FIGURES compiled as of March 31, 1953. The report shows, of 33,317 physicians in Priority III, a total of 6,920 has been passed physically and placed in I-A. Still holding deferment (2-A) were 1,330 Priority I and II physicians, many of whom may anticipate transfer to 1-A when residency training year comes to close June 30. In addition, there are still 596 physicians in I and 158 in II who are physically acceptable, but not yet tapped. Grand total of registrants shows 100,718 physicians of whom nearly half are in Priority IV (veterans).

OSTEOPATHS SEEK RECOGNITION FOR COMMISSIONING in the armed forces. HB 5017, sponsored by Rep. Dewey Short (R., Mo.) would provide that OD's who are licensed to practice medicine and surgery would be acceptable for commissioning the same as MD's.

PRESIDENT BACKS MEDICAL EDUCATION DRIVE. The financial crisis facing medical schools is "a dangerous threat to the national welfare, which must be met," President Eisenhower said recently in opening the \$10,000,000 campaign within industry and the medical profession to help the schools overcome deficits threatening their teaching and research programs.

The President's views were expressed in a long letter to S. Sloan Colt, New York banker and president of the National Fund for Medical Education. One paragraph of the letter said:

"As I wrote to you on January 6, the financial problems of the medical schools should be solved through private, rather than governmental means.

Excessive reliance on government violates the essential principle of our free enterprise system. It falls, then, upon American business to assume a greater share of the responsibility for maintaining the institutions essential to our national health."

SECRETARY HOBBY'S BUDGET \$64 MILLION UNDER TRUMAN BUDGET. Secretary Hobby's Department of Health, Education, and Welfare proposes to carry on its work next fiscal year on about \$64 million less than the Truman administration had recommended. The new Hobby-Eisenhower budget would keep the Department's costs at about their current level, when liquidating funds and non-recurring obligations are taken into account. However, Public Health Service would take a substantial cut—more than \$60 million below present spending.

Funds for the Hill-Burton hospital construction program would be cut from the current \$75 million to \$60 million.

Also scheduled for sizable reductions are three of the seven national health research institutes and the National Institutes of Health, which does much of the administrative work for the individual institutes. A breakdown includes the following, expressed in millions of dollars:

	Current Spending Proposed Spending		
	(Fiscal 1953)	(Fiscal 1954)	Changes
Food and Drug Administration	\$5.6	5.6	0.00
Office of Vocational Rehabilitation	22.95	23.69	+ 0.74
Children's Bureau	30.15	32.15	+ 2.0
Public Health Service	284.42	219.66	—64.75
National Institutes of Health	5.01	4.68	— 0.34
Cancer Institute	17.52	15.78	— 1.74
Heart Institute	11.77	11.04	— 0.74
Mental Health	10.82	9.82	— 1.00
Dental Health	1.65	1.74	+ 0.09
Arthritis & Metabolic	4.57	4.97	+ 0.41
Microbiology	5.48	5.74	+ 0.26
Neurology & Blindness ..	1.97	2.57	+ 0.60

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INDICATIONS FOR SURGERY IN JAUNDICED PATIENTS

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THE APPARENT increase in the number of jaundiced patients from a variety of causes has focused greater attention on the part of physicians dealing with the problem of differential diagnosis between so-called medical versus surgical jaundice. Although the number of laboratory tests for evaluating the jaundiced patient has likewise increased, it is doubtful if the indications for surgery have been either simplified or made foolproof. The disagreeable symptoms which accompany jaundice are trying to the patient, and their evaluation offers a challenge to the physician until the cause has been determined and effective treatment instituted. Obviously, the patient benefits much more when the correct decision is made early. How can the busy physician most effectively select those

patients whose jaundice can be relieved only by surgical intervention? Has the ever increasing number of liver function tests replaced clinical judgment based on a thorough history and physical examination? In an attempt to evaluate some of these points a series of cases comprised of 100 consecutive jaundiced patients was studied, in each of whom the diagnosis was confirmed by operation.

An analysis of the 100 cases showed that the correct preoperative diagnosis of obstructive (surgical or extrahepatic) jaundice had been made in 89 patients. A benign cause was found in approximately one out of two cases, a malignant cause in one out of three cases, and a non-surgical (medical) cause in approximately one out of ten cases. Since the latter group was not correctly differentiated from surgical jaundice an unnecessary exploration resulted.

The obstructive jaundice in the 89 patients correctly diagnosed before surgery was limited to a relatively few causes. In 44 of the cases one or more stones were removed from the common

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duct, and in four patients a stone was not recovered but was presumed to have passed recently into the duodenum. It is regrettable that a postoperative stricture of the common duct was found in seven patients who had previously undergone gallbladder surgery elsewhere. Despite the many articles calling attention to the potential dangers of gallbladder surgery all too many strictures result.^{1,2} Twenty-one cases of carcinoma involving the head of the pancreas or the papilla of Vater comprised the majority of the malignant group of 34 cases, but surprisingly enough carcinoma of the bile ducts was responsible in 10 of the cases. In three patients metastatic malignancy from the gastro-intestinal tract produced extrahepatic obstruction.

Therefore, for practical purposes, the indications for surgery in jaundiced patients can be narrowed down to the patient's having a diagnosis of common duct stone, postoperative stricture, or carcinomatous obstruction of the extrahepatic ducts.

A thorough history, including a careful analysis of the prodromal symptoms preceding the onset of jaundice will ferret out the majority of the surgical cases from the larger group of jaundiced patients. The diagnosis of obstructive jaundice from a common duct stone is usually associated with a past history of gallbladder disease. Approximately seven out of ten of these patients will give a typical history of biliary colic. However, it must be remembered that silent jaundice from obstruction by a common duct stone is not unusual. Following our distention experiments of the gallbladder and common duct in patients, we have been impressed with the high incidence of pronounced nausea and vomiting which occurs when the common duct is involved as compared with the distention of only the gallbladder.⁶ The reliability of this finding has been recently stressed by Strohl, et. al.⁴ In our series of patients with common duct stone eight out of ten gave a history of rather pronounced nausea and vomiting accompanying each attack. Chills and fever which many times were rather mild occurred in three out of five patients while a similar percentage of patients had a recurrent type of jaundice.

Mention might be made of the reliability of jaundice in establishing the diagnosis of common duct stone. Too frequently the surgeon may not

seriously consider exploring the common duct for calculi unless the patient is jaundiced at the time of operation. Since the results of biliary surgery can be further improved if fewer common duct stones are left behind after cholecystectomy, it is important to emphasize how silent and atypical the history of common duct stone may be. In another series of ours consisting of 100 consecutive cases in whom a common duct stone was recovered there was no history of jaundice in 35 per cent, a past history in 21 per cent and only 44 per cent were actually jaundiced at the time of surgery.

Two associated diseases, namely acute cholecystitis and acute pancreatitis, were not uncommonly found in the jaundiced patients having a common duct stone. Although the cystic duct is usually blocked by a calculus in acute cholecystitis, it should not be assumed that a previous stone did not escape into the common duct. In our experience the incidence of recovery of common duct stones associated with acute cholecystitis is almost one half the percentage found in all types of biliary tract surgery. In this series of 100 consecutive jaundiced patients the incidence of associated acute cholecystitis with common duct stone was one out of ten cases, and an elevated serum amylase level strongly supported the diagnosis of an associated acute pancreatitis with common duct stone in one out of seven cases. Although these associated diseases complicate the preoperative preparation and dictate the proper timing for operation, they are valuable in supporting the indications for surgery.

The history in cases of obstructive jaundice due to malignancy may not be as helpful as in the patient with a common duct stone. The so-called typical case with a painless and progressive jaundice in an elderly thin male offers little difficulty in diagnosis. However, as others have shown, more than half of these patients do have bizarre upper abdominal pain which may be quite severe. Only one out of three patients in this series had what might be termed a painless jaundice. Therefore, painless jaundice is not a consistent and reliable diagnostic sign of obstruction due to malignancy. More diagnostic significance should be attached to persistent jaundice of increasing intensity.

Although a weight loss of more than 20 pounds was present in two out of three patients with

malignant obstruction, it was surprising how frequently the intolerance of food or fear of inducing colic by eating had produced a substantial loss of weight in the majority of the benign group of jaundiced patients. The value of knowing the patient's weight loss is a more important consideration in forced nutritional replacement, whether for medical reasons or as a preoperative preparation, than as a diagnostic aid in differential diagnosis. Although itching has been heralded as strong evidence in favor of surgical jaundice we have found this symptom to be of little diagnostic significance.

The development of jaundice immediately following cholecystectomy strongly suggests injury to the common bile duct. Usually there have been technical difficulties from inadequate exposure or in controlling hemorrhage deep in the operative site. Regardless of the time interval during which jaundice develops in a patient who has had previous gallbladder surgery, the physician should make every effort to ascertain the details of that procedure.

In the early postoperative period stricture of the common bile duct, an overlooked common duct stone, or hepatitis from transfusions are the most likely diagnoses. In the late postoperative period common duct stone is the most probable cause especially if the gallbladder was only drained by cholecystostomy. We have also observed several patients in whom calculi had reformed in a dilated retained cystic duct stump and eventually passed into the common duct.

The biliary tract has always fascinated anyone attempting abdominal surgery, but nature has handicapped even the most experienced surgeon by providing more anatomical variations in the region of the cystic duct than anywhere else in the entire body. The necessity for a secondary operation to remove overlooked pathology is unfortunate in itself, but the patient in whom a stricture of the common duct has resulted is usually in a more serious condition than before the first operation, regardless of the severity of the initial symptoms.

Although the physical examination of the jaundiced patient may be disappointing it is more likely to be contributory in surgical jaundice. A clinical impression can often be gained by observing the intensity of the jaundice. The intense greenish yellow of complete surgical jaundice from malignancy has been contrasted to the

canary yellow of severe liver damage such as acute yellow atrophy of the liver.

Since the liver is usually enlarged and tender in the presence of jaundice of many types, it contributes little to the differential diagnosis unless distinct metastatic nodules can be palpated. Evidence of either primary or recurrent carcinoma in the gastro-intestinal tract suggests a metastatic spread to the region of the hilum of the liver. On the other hand, an enlarged spleen increases the diagnostic possibilities considerably. Congenital or acquired hemolytic anemia and cirrhosis of the liver must be considered and extensive hematological investigation is required before surgery can be recommended.

The finding of a distended gallbladder in the presence of obstructive jaundice from carcinoma is of considerable importance and certainly a point commonly emphasized. Every student remembers Courvoisier's Law as it applies to the physical examination of the gallbladder region. In the presence of intense jaundice a distended, easily palpable gallbladder is indicative of surgical jaundice from carcinomatous obstruction of the lower end of the common duct. In our series a distended gallbladder was palpable in two-thirds of the patients with carcinoma of the head of the pancreas. The absence of a distended gallbladder in the presence of jaundice favors the diagnosis of a common duct stone since the chronically infected gallbladder, which is invariably associated with cholelithiasis, cannot distend in response to the common duct obstruction. And, lastly, an easily palpable, non-tender gallbladder in the absence of jaundice is indicative of a hydrops from a stone occluding the cystic duct. The principles of Courvoisier's Law are certainly worth remembering in the investigation of the jaundiced patient.

Only after a thorough history and physical examination have been summed up in a definite clinical impression should the results of any laboratory tests be evaluated. From the large, so-called battery of liver function tests, the physician should select a few most likely to indicate a medical jaundice and a few to support a diagnosis of obstructive or surgical jaundice. When these tests are carried out early, the chance of obtaining some help in differential diagnosis is improved. If the physician delays obtaining any liver function tests for several weeks, hoping that the jaundice will subside, he nullifies the

diagnostic value of many of the laboratory findings which might support surgical jaundice. Eventually superimposed liver damage from the prolonged obstruction may become evident in the laboratory tests and result in mixed or non-diagnostic findings. In ordinary hospital practice the number of laboratory tests on a jaundiced patient will approximate two dozen. If we were held to a minimum of laboratory tests we would select the icteric index as a base line for the progress of jaundice, an alkaline phosphatase for evidence of extrahepatic obstruction, and the prothrombin time, cephalin flocculation and thymol turbidity to assess the amount of cellular liver damage.

These tests provided, to a surprising degree, the primary diagnostic support in the differentiation between medical and surgical jaundice. For example the cephalin flocculation and the thymol turbidity were elevated about 20 in 80 per cent or more of the cases of medical jaundice subjected to surgery. In contrast the cephalin flocculation showed a similar elevation in only 2.5 per cent of the cases of common duct stone and in 13 per cent of the malignant obstructions. The thymol turbidity test was not as significant since there was an elevation to 40 per cent in the former and 33 per cent in the latter cases. The alkaline phosphatase test was elevated in 88 per cent of the malignant obstructions, in 48 per cent of the benign obstructions and in 44 per cent of the medical cases seen. The icteric index was consistently over 100 in 60 per cent of the malignant obstructions, in 10 per cent of the benign obstructions and in 20 per cent of the medical cases.

There are justifiable reasons for the variations shown in these 100 cases. The jaundice in approximately one third of the cases had existed longer than one month and during this period secondary liver damage was no doubt superimposed upon the obstruction. There was also evidence of intrahepatic obstruction from primary liver damage in one half of the non-surgical cases. These factors provide contradictory evidence, and tend to re-emphasize the extreme importance of early laboratory evaluation followed by repeated checks for confirmation of a trend to either support or nullify the recommendation for surgery.

Like others we have a great deal of respect for the prothrombin level as an index of liver

damage. A prothrombin level below 50 per cent of normal which does not respond to Vitamin K therapy is indicative of severe cellular liver damage. Rarely is a patient accepted for surgery of any type whose prothrombin level will not elevate well above 50 per cent in response to Vitamin K.

While reliance should be placed on a relatively few laboratory tests insofar as differential diagnosis is concerned there are others which are quite helpful in evaluating the patient as a surgical risk. Although the total serum protein was low in one third or less of the cases, the albumin globulin ratio was altered in one fifth of the benign obstructions and in one half of the malignant, as well as the non-surgical, cases. Of considerable importance was the elevation of amylase in 21 per cent of the cases of benign obstruction. It is surprising how frequently pancreatitis is encountered if the blood amylase levels are determined early and routinely.

While blood analyses require extensive laboratory facilities, the physician can readily gain valuable diagnostic assistance from repeated examinations of the stool and urine. Gray stools imply an absence of bile and if consistently so discolored, surgical intervention is strongly indicated. Although the test for bile in the urine is simple, it is of no diagnostic significance unless absent in the presence of jaundice. Under these circumstances of acholuric jaundice a diagnosis of congenital or acquired hemolytic anemia should be suspicioned. In the presence of a complete obstruction, bile does not reach the intestine to be converted to urobilinogen, and consequently, will be absent in the stool. Normally the urobilinogen is reabsorbed from the bowel and varying amounts are excreted in the urine. Obviously if it is absent in the intestine, there will be no urobilinogen excreted in the urine. The Ehrlich aldehyde test can easily be applied to a urine sample to determine the presence or absence of urobilinogen. When it is absent in repeated tests one may assume that the patient has an obstructive jaundice which requires surgical intervention. Unfortunately, except in complete obstruction, varying amounts of bile may reach the intestine and the above test requires, to be valid, a more complicated 24 hour estimation of the amount of urobilinogen excreted.

We were surprised to find that tests for urobilinogen had been run rather infrequently and

certainly without sufficient thoroughness to be of much help in the diagnosis of the 100 cases studied. Similarly we found the van den Bergh test rarely influenced our clinical impression except in the cases of hemolytic jaundice where the indirect reaction is so consistently elevated.

We were especially interested in the eleven non-surgical cases that had unnecessary surgery, since this group represents a mistaken preoperative diagnosis of obstructive or surgical jaundice. Although a failure in approximately one out of ten cases might be condoned, on the other hand surgery had nothing to offer these patients except an increased morbidity and possible mortality. The diagnosis established at the time of operation was as follows: hepatitis, 5; biliary cirrhosis, 3; cholangitis, 2; and diffuse involvement of the liver with Hodgkin's disease, 1. On the justifiable side as far as we were concerned was the fact that one half of these patients had gallstones by x-ray and there was laboratory evidence favoring obstructive jaundice in one half of the cases. A very careful analysis was made of all aspects of diagnosis and management in an effort to avoid such mistakes in the future.

Two factors did stand out which tended to condemn the indications for surgery. In the first place approximately 80 per cent of the eleven medical cases had high cephalin and thymol readings clearly indicating rather severe liver damage. Furthermore, about one half of these patients had been operated upon too quickly (10 to 14 days) after the onset of jaundice without allowing sufficient time to re-evaluate the suggestive laboratory evidence. Actually one half of the patients in this group had obstructive jaundice of the intrahepatic type due to severe liver damage. Although the jaundiced patient must not be "studied to death"³ before operation, it is often desirable to delay surgery until the diagnosis of surgical jaundice is more certain. If the physician, after completing the history and physical examination, sums up his evidence as to the probable cause of jaundice, he should feel sufficiently secure in his impressions to resist changing his diagnosis except in instances of most convincing and sustained laboratory evidence. This is not wasted time if the patient is energetically treated in preparation for possible operation.

Certainly no jaundiced patient should be subjected to surgery without a complete gastro-in-

testinal x-ray study regardless of how obvious the diagnosis may seem. The discovery of unsuspected malignancy, distortion of the duodenum from carcinoma of the head of the pancreas or papilla of Vater, and appearance of gallstones are all invaluable in establishing a diagnosis in the jaundiced patient. Although cholecystograms, for obvious reasons, are considered inaccurate in the presence of jaundice, we were surprised how often this test, with the resulting evidence of gallstones, had been ordered by the house staff.

A needle biopsy of the liver is used in many clinics as an accurate and safe diagnostic method of making a differential diagnosis in cases of jaundice.⁵ In experienced hands, it appears to be a very safe and reliable diagnostic procedure. Since we have observed massive intraperitoneal hemorrhages as well as bile peritonitis following this procedure, we do not share the enthusiasm of some of our medical colleagues as to the safety of this procedure. Certainly it would seem to be advisable in the presence of marked extrahepatic obstruction.

The improvement of nutrition should be the primary preoperative goal for the jaundiced patient. The wisdom of supplying calories and protein to the patient with liver disease has been clearly shown by Ravdin. However, there appears to be a general tendency to meet these caloric demands in a rather routine half-hearted manner by administering glucose intravenously for a few days preoperatively without paying close attention to the patient's oral intake. Metabolic studies in our clinic and elsewhere have shown that jaundiced patients lose one-third or more fat ingested. Fat is a rich source of calories and the loss should be held to a minimum. We have found it advantageous to force-feed some of these patients through a small polyethylene nasogastric tube. The fat absorption is improved almost to normal by the addition of 1 cc. of Sorlate^R (Tween 80) to each quart of milk in the feeding mixture. If the patient has a biliary fistula we have cannibalized bile from other post-operative patients and mixed it with the milk given through a nasogastric tube.

Vitamin deficiencies were corrected by the administration of Vitamin K to insure a prothrombin level above 50 per cent of normal. One gram of Vitamin C and B complex were supplied daily. Prophylactic antibiotic therapy in the form

of streptomycin, aureomycin and penicillin were given if there was evidence of sepsis. Such prophylaxis has some merit in protecting the liver should the blood supply be inadvertently injured, especially in difficult secondary operations.

In addition to oral and intravenous feeding any anemia or protein deficiency should be corrected. This is especially important as shown in our cases where two out of three had lost over twenty pounds in weight and well over one half of these jaundiced patients had an inadequate caloric intake. Routine blood counts and serum protein determinations showed only one out of four of these patients to have a blood volume and tissue protein deficit greater than 20 per cent. This provided a false sense of security as shown by the more accurate blood volume measurements. Utilizing radio-active iodinated human serum albumin in small dosage, it was possible to make serial blood volume determinations in these jaundiced patients with a much greater degree of accuracy than hitherto possible with Evans blue dye. These results showed that 75 per cent of the cases, rather than 25 per cent, were in deficit over 20 per cent of their calculated normal. The deficits were met by repeated blood transfusions, administration of human albumin, protolysates and finally, if necessary, by plasma. We are convinced of the value of repeated blood volume determinations in the preoperative preparation of these poor risk surgical patients.

It is always advisable to re-evaluate the jaundiced patient before setting a definite time for operation. Surgery should be delayed if the resurvey of the history and physical examination is indecisive between medical and surgical jaundice. Likewise, certain laboratory tests stand out as danger signals which must not be ignored. If the cephalin and thymol tests are elevated or increased, the presence of intrahepatic cellular disease (hepatitis) rather than surgical jaundice should be considered. A reversal of the albumin globulin ratio which is not corrected by adequate preoperative preparation should also be a reason for delaying operation. Finally, low cholesterol esters, a test we did not use frequently enough, and the failure of the prothrombin level to rise well above 50 per cent in response to Vitamin K therapy are highly suggestive of advanced cellu-

lar liver damage. As previously stated, we have tended to refuse surgery to any patient unless the prothrombin level can be adequately elevated above 50 per cent.

To insure a low morbidity and mortality rate the jaundiced patient requires more work and study in all aspects of diagnosis and treatment than almost any other type of patient. If a well formulated plan is followed it is possible to select with a high degree of accuracy those jaundiced patients most likely to be relieved by surgery. Very gratifying results are obtained if a common duct stone is recovered. The repair of strictures, while not as uniformly successful, is always worthwhile regardless of how many previous repairs have been attempted.

Although relatively few malignancies producing obstructive jaundice can be surgically extirpated, the individual patient should be given this opportunity. In our series exploration was definitely worthwhile in two out of three of the 34 patients having obstructive jaundice from carcinoma. All were relieved of their jaundice which was certainly worthwhile as far as the comfort of the patient was concerned. In three cases the head of the pancreas was resected without a mortality. One out of three patients were less fortunate in that the malignancy was so far advanced that nothing more than proof of the diagnosis was established.

The patient with obstructive jaundice, regardless of age, should be given the benefit of surgical exploration. In a great majority of instances the benign cause can be removed and even in the presence of inoperable malignancy, relief of the jaundice, so greatly appreciated by the patient, can be effected.

Conclusions

1. A clinical impression based on a thorough history and physical examination of the jaundiced patient should be made before evaluating the laboratory evidence.
2. Laboratory tests, if made early and repeatedly, provide valuable support in differentiating between medical and surgical jaundice.
3. Gray stool, decreased or absence of urobilinogen in the urine and elevated blood alkaline

phosphatase support the diagnosis of surgical jaundice.

4. Elevated cephalin flocculation and thymol turbidity, poor prothrombin response to vitamin K, and low cholesterol esters support the diagnosis of medical jaundice and are reasons for delaying surgery.
5. Nutritional replacement by forced feeding with the addition of bile or Tween 80 and accurate replacement of blood volume deficiencies decrease the surgical risk.
6. Neither age nor etiology is a contraindication to surgery in extrahepatic jaundice since the cause can be removed or palliation provided in a high percentage of cases.

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European Trained MD Contributes to AMEF

A European-educated physician now residing in Madera, California, believes that physicians should support American medical schools. Although he owes no allegiance to any school in this country, Dr. Thomas Klein sent in a donation to the American Medical Education Foundation. His action sets an example for graduates of American medical colleges. In less than three months of this year, the Foundation has received in excess of \$657,000 from more than 7,000 contributors towards its 1953 goal of two million dollars.

ABDOMINAL EMERGENCIES DUE TO:

1. Non-Penetrating Abdominal Trauma
2. Those Secondary to Lesions in the Gynecologic System

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THE TASK of discussing those lesions requiring emergency abdominal surgery which come about as, first, the result of non-penetrating abdominal trauma and, second, disorders of the upper female genital tract has been assigned to me. Since this is a big subject an effort will be made to bring out only some of the fundamental principles involved and to point up those aspects of the subject which seem important; yet are apt to be overlooked. In an effort to present the matter in a somewhat orderly fashion the first part of the discussion will be limited to the subject of non-penetrating abdominal trauma, and the second to lesions of the gynecologic system which may bring about emergency abdominal surgery.

It seems wise at this point to emphasize that which no doubt the moderator and the other discussants will also stress, and that is, emergency surgery of all types should be kept at the absolute minimum consistent with good medical care. In fact, there are only two conditions which may require immediate abdominal surgery, and these are massive hemorrhage and gross intra-peritoneal soiling, such as one may see after the perforation of a hollow viscus. Even here, the emergency is not so great as to preclude a general physical examination, even if somewhat cursory, and simple laboratory aids, such as a urinalysis for blood, or an x-ray of the abdomen for free air under the diaphragm. A real effort should be made to establish a fairly accurate diagnosis of the local lesion and, in the case of trauma, to detect associated injuries. This can

be done rapidly and at the same time the patient's general condition evaluated, and appropriate treatment begun for such things as shock which is so frequently found. It should be kept in mind that emergency surgery is apt to be carried out at odd hours, or at times when only skeleton crews are on duty in the operating rooms, and that the personnel of the operating team is apt to be fatigued and not at its best. Under these circumstances the surgeon may not be able to obtain adequate retraction to safely visualize the working field, or the members of the team may be somewhat new and not accustomed to working together. These factors may lead to some minor errors, or occasionally to some serious ones. It is undoubtedly true that the more experienced a surgeon becomes the lower becomes his percentage of emergency operations, and in these he will have adequate teams to execute the procedure safely.

Non-Penetrating Abdominal Trauma

These injuries are usually caused by blunt objects and are more difficult to evaluate than are those in which there is an open wound. The history of the type of blow or force applied, its location, and whether or not it was associated with immediate pain are important. For instance, severe trauma over the left flank may tear the spleen or left kidney, or both, and produce massive hemorrhage. If the ribs on this side are fractured there may be immediate and severe pain; the pain being increased by movement of the thoracic cage. On the other hand, one may obtain the history of the patient having had a full bladder at the time of injury and of having experienced severe lower abdominal pain shortly thereafter. This type of history, particularly when associated with the finding of an injury to

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the bony pelvis, may indicate a rupture of the urinary bladder. Or there may be a history of a groin hernia over which the patient was wearing a truss; the point of maximum force having been applied to this apparatus. Under such conditions a loop of small bowel may be caught between the metal of the truss and the os pubis with the result that it is torn. Under these circumstances the patient is apt to experience immediate pain as the result of irritating liquid small bowel contents striking the sensitive parietal peritoneum.

In the diagnosis of the lesion caused by blunt abdominal trauma one should attempt to learn, if possible, the type of force applied, the direction from which it came, and whether or not it was associated with immediate severe pain or shock. In the case of injury to the solid intra-abdominal organs, such as the liver and spleen, the subsequent symptoms are due primarily to hemorrhage, and there may be a latent interval of comparative well being between the time of injury and that of the onset of severe symptoms. It should be recalled that blood is irritating to the peritoneum, and since it will tend to pool in the most dependent portions of the peritoneal cavities, symptoms referable to these areas may be noted. For instance, free blood in the cul-de-sac or rectovesical space usually causes the patient to complain of a frequent desire to urinate or defecate.

When the hollow viscera are torn the patient usually complains of immediate pain, particularly if the viscus contains irritating contents, such as that in the stomach or duodenum. The classic picture of this type of injury is that illustrated by the acute free perforation of a duodenal ulcer. The peritoneum is bathed with a fluid containing an irritating chemical content, and the clinical picture produced is so well known as not to require further comment. Not so well appreciated perhaps is that injury to a hollow viscus in which the content is mainly infective, and in which the subsequent symptoms are produced, not primarily by chemical irritation but by bacterial infection of the peritoneum. This is illustrated by tears in the left colon in which the escaped contents may be rather firm fecal material, which at first does not produce marked symptoms.

These patients with a history of blunt abdominal trauma should be carefully questioned along the lines just enumerated and a rapid but complete physical examination carried out. This may reveal associated injuries and also gives the examiner an opportunity to evaluate the patient's general condition. The urine must be examined for blood, both gross and microscopic, and a finger inserted in the rectum in order that a specimen of fecal material may be obtained for inspection. Bright blood found in this area, for instance, suggests injury to the left colon, and may necessitate additional appropriate diagnostic procedures such as sigmoidoscopy. If the physical examination yields external signs, such as contusions, special attention must be directed toward the examination of the organs in this area, not forgetting however that blunt force is transmitted and may cause injuries to organs at a distance.

In addition to inspecting and palpating the abdomen one should listen to it carefully and at some length with a stethoscope. A silent abdomen, or one in which the peristaltic sounds are greatly reduced, demands most thoughtful consideration. It is suggestive of an ileus due, in this instance, either to chemical or bacterial inflammation. This type of picture, of course, can also be produced by retroperitoneal bleeding and trauma such as one sees with compression fracture of the lumbar vertebrae.

An x-ray film of the abdomen, with the patient erect, may reveal free air under the diaphragm. In the case of intraperitoneal tears of the urinary bladder the injection of air can be noted under the diaphragm. This frequently causes referred pain to the top of the corresponding shoulder.

It is assumed, of course, that the examiner will record the pulse rate, blood pressure and temperature. If, after a history and physical examination, and the few laboratory aids enumerated, the diagnosis is not clear, and there are no signs of urgency, one is justified early in the course of the management of blunt abdominal trauma to institute a short period of frequent clinical observations. If, during this period of time, reasonable doubt as to the presence of serious injury still exists in the mind of the observer the abdomen should be explored.

Pre-Operative Preparation and Operation

If a decision is made to advise surgery the surgeon should make a tentative diagnosis of the primary lesion and advise the operating room nurses, so that they can prepare the appropriate instruments and be somewhat forewarned as to what to expect. It is assumed that the patient's general condition will have already been evaluated, associated injuries noted, and proper treatment begun for such things as shock. It is important that these patients be brought to the operating room with an empty stomach. If necessary, the stomach should be emptied with a large calibre tube. The importance of this is emphasized by the report of Kingsbury,¹ which showed 2 out of 12 deaths due to aspiration of gastric contents; the deaths occurring on the operating table. Aside from the factor of aspiration of gastric contents it is necessary to have the stomach deflated in order to obtain adequate exposure, particularly of the spleen. The lower thoracic cage, as well as the entire abdomen, should be shaved and prepared, making it easy to extend incisions in either direction and, if necessary, to enter the thoracic cavity.

The type of incision and its placement will depend to some extent on what one expects to find after entering the peritoneal cavity. In general, straight incisions in the rectus muscles are preferred in that they permit more flexibility in the event that it is necessary to extend them. The surgeon should be prepared to encounter perhaps a gush of blood when the peritoneum is opened and should have suction immediately available. It should be kept in mind that under such conditions sponges and packs may be lost, and that it is probably wise to dispense with all except large packs, and these should have markers with large metal rings attached. Free blood and blood clots should be removed, and if there is active bleeding it should be controlled before proceeding with the exploration. In examining the peritoneal contents one should proceed from one fixed point to another, examining each part in an orderly, systematic fashion and dealing appropriately with each injury as it is encountered. In case lacerations of the liver are sutured one should institute drainage, preferably through dependent counter-stab incisions. In such cases small bile ducts will almost surely have been torn making it necessary to establish

external drainage. It may be advantageous to close the abdomen with through and through silver or steel wire. Such a closure is aided if large needles are threaded on each end of the wire and the suture introduced from the peritoneal side of the incision and thrust outward.

Abdominal Emergencies Due to Lesions of the Female Upper Genital Tract

In discussing lesions of the female upper genital tract which may lead to emergency abdominal surgery it seems wise to divide these into two categories, namely; those not due to or associated with pregnancy, and those due to pregnancy. It is admitted that such a division is an artificial one, and that any woman in the childbearing period may be pregnant along with whatever else may ail her. It is hoped, however, that such a division will permit of a more orderly discussion of the main lesions involved.

Diseases Not Commonly Due to Pregnancy

Acute bacterial inflammation of the fallopian tubes is not commonly seen these days, but it is to be remembered as a disease which can closely simulate acute appendicitis. In general, the history of continuous, aching lower abdominal pain, making its appearance just after a menstrual period, associated with a profuse vaginal discharge and bilateral lower abdominal tenderness, serves to identify the disease correctly. In some instances, however, it is impossible to differentiate between acute adnexal inflammation and acute appendicitis. Therefore, one must always exclude acute appendicitis before making a diagnosis of acute salpingitis. If one is unable to do so, surgery is indicated. In those uncommon instances of error the benign appendix can be removed leaving the acutely inflamed tubes undisturbed and treating the infection in them postoperatively with antibiotics.

Tumors of the uterus, tubes or ovaries, nearly always benign and non-inflammatory in nature, may have a long base or stem which tends to lend them considerable mobility. When they become twisted the pain is nearly always cramp-like in nature, tends to radiate towards the midline, and is described by the patient as being "just like menstrual cramps." Late in the course of the illness, after ischemic necrosis has set in and there is some adjacent peritonitis, the pain

will be continuous in character and associated with localized tenderness. An interesting and occasionally useful observation is that the twist is in a clockwise direction. Volvulus of the cecum, the distended viscus lying in the lower abdomen, occasionally causes confusion in diagnosis. However, volvulus of the cecum is an extremely rare clinical entity.

Diseases Associated with Pregnancy

For purposes of discussion a division will be made between those lesions occurring early in pregnancy and late in pregnancy which may produce symptoms leading one to believe that emergency abdominal surgery may be indicated. In the first category one places the extra-uterine pregnancy, usually tubal in type, with massive free intraperitoneal hemorrhage, as being the most dramatic and most common. The diagnosis in such circumstances is usually easy. One should keep in mind, however, that there may be variable amounts of intraperitoneal hemorrhage; the bleeding occurring over a period of time and, in some instances, making the diagnosis very confusing. There are few abdominal surgeons of wide experience who, at some time or another, have not confused acute appendicitis, acute salpingitis, or even acute cholecystitis with ectopic pregnancy. It is sometimes difficult to differentiate between this condition and intrauterine pregnancy with threatened or actual abortion. Ruptured ovarian cysts with intraperitoneal hemorrhage produce an almost identical picture. At operation only the diseased tube should be removed, carefully protecting the corresponding ovary. Associated incidental appendectomy should not be undertaken.

The essayist has been asked to comment on emergency Cæsarean Section as a cause for emergency abdominal surgery but will do no more than say that these are usually limited to the last trimester, and are limited to lesions which threaten the life of the mother or of the child, such as rupture of the uterus, premature separation of the placenta, or placenta prævæ with massive hemorrhage. An uncommon and interesting lesion is that of inversion of the uterus

usually brought about by too vigorous Crede procedure. The blood loss here is massive and volume for volume replacement is in order. Reduction is accomplished by pressure from below and traction above on the round ligaments.

Summary and Conclusions

Some of the lesions resulting from blunt abdominal trauma and diseases of the upper female genital tract which may lead to emergency abdominal surgery have been discussed. The patient suffering from a non-penetrating abdominal wound should have, prior to surgery, a complete, physical examination, with laboratory aids, such as complete blood count, urinalysis, and x-ray of the abdomen. A tentative diagnosis should be established and associated lesions noted. During this period of time the patient's general condition can be evaluated and appropriate treatment given to improve his condition for surgery, if indicated. The emergency is never so great as to preclude these measures. In those cases of trauma in which the surgeon suspects that there may be injury to an intra-abdominal organ a period of frequent observations shortly after the injury is advisable. If, after this, reasonable doubt still exists as to the exact diagnosis, the abdomen should be explored and its contents examined under direct vision. In those cases in which chemical or bacterial contamination of the peritoneal cavity is suspected the indications for intervention are more urgent; the time interval between injury and surgical intervention being kept as short as possible.

Emergency surgery of all types should be kept at the minimum consistent with good medical care. The haste and confusion sometimes encountered under emergency conditions, along with tired, sleepy, and perhaps inadequate surgical teams may lead to errors in surgical judgment and mistakes in surgical technic.

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VIRAL HEPATITIS IN 1952

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THIS YEAR can be marked as the tenth anniversary of the modern knowledge of viral hepatitis. At this time ten years ago we had just completed our first mass experience with hepatitis in World War II. It will be recalled that this was an outbreak of jaundice following the widespread use of yellow fever vaccine in personnel of the armed forces.¹ The vaccine was at that time made up of attenuated yellow fever virus suspended in a menstruum of human serum. Two to four months after inoculation with this vaccine, certain recipients developed jaundice. It was demonstrated that the incidence of hepatitis was as high as ten per cent of personnel exposed to known icterogenic lots.² This epidemic of "serum hepatitis" came to an end after the serum-containing vaccine was withdrawn and was replaced with a new material not containing human serum. However, this did not mark the end of our experience with hepatitis in the armed forces in the period of World War II. In the years 1943 to 1945 other epidemics appeared in the Mediterranean, the European and the Pacific Theaters of Operation.^{3, 4}

As a result of the experience with this disease during World War II study groups were organized and investigative efforts were initiated to explore the problems of viral hepatitis. These studies have continued and are active at the present time.

That the problems of the spread of hepatitis have not yet been adequately solved, is shown by the recent experience with this disease in laboratory workers,⁵ certain communities,⁶ occupation troops,⁷ blood banks⁸ and army installations in

the United States.⁹ The interest in hepatitis in 1952 is mainly centered around the problems of diagnosis, treatment and prevention.

Diagnosis

Since hepatitis is a disease that may appear in any geographical area, in any season of the year, in any race and in any sex, it must be considered in the differential diagnosis of many conditions of acute onset with or without jaundice.¹⁰ In a known epidemic of hepatitis the diagnosis may be made with relative ease, but when the disease appears sporadically, especially in older age groups, it may prove to be a distinct challenge to the diagnostic ability of the physician.¹¹ The problem of diagnosis is present particularly in the deeply jaundiced individual whose disease has a painless and insidious onset. Although the naturally occurring form of hepatitis (epidemic hepatitis), usually appears with an abrupt onset of anorexia, nausea and vomiting, the artificially transmitted form of hepatitis (homologous serum hepatitis), we are now seeing in greater numbers, may have a very insidious onset with few or no symptoms other than the development of dark urine and yellow scleras. In this latter group of cases the physician must turn to the laboratory for aid in the differential diagnosis.

In the past ten years a great deal of progress has been made in the laboratory diagnosis of hepatitis. It must be emphasized repeatedly however, that *there has been no single test or combination of tests yet devised which will unequivocally point to or away from the diagnosis of viral hepatitis.*

Despite the lack of absolute reliability, the biochemical measurements of hepatic function have a useful place in diagnosis and in following the course of hepatic disease.¹² We have learned to group liver function tests mainly into two categories: those related to the excretory function of the liver and those related to liver cell func-

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tion. The tests in common use which relate to excretory function are the serum bilirubin, the urine bilirubin, the bromsulfalein and the alkaline phosphatase. The thymol turbidity, cephalin cholesterol flocculation, urine urobilinogen, prothrombin time, cholesterol-cholesterol ester ratio, serum proteins and hippuric acid synthesis, on the other hand, are tests which are believed to reflect liver cell damage. In the main a patient with extrahepatic obstructive jaundice will show abnormalities only of the tests of excretion. A patient with a diffuse hepatocellular disease such as hepatitis will show abnormalities both of excretion and of liver cell function. The number and type of tests selected in any given case will depend upon their value in diagnosis, their simplicity and their general availability in the community. After extensive studies with a large number of cases^{12,13} it has been found that a panel of tests including the serum bilirubin (one minute and total), the bromsulfalein, the cephalin flocculation, the thymol turbidity, the urine bilirubin and the urine urobilinogen meet the above criteria and are of value not only in the differential diagnosis of jaundice but also in following the course of disease when measured serially at weekly intervals.

When all of the above tests are found to be abnormal in a given patient with symptoms of anorexia, nausea, vomiting, low grade fever, liver enlargement and tenderness of acute onset, the diagnosis of viral hepatitis should be strongly entertained. When both the cephalin flocculation and the thymol turbidity tests are found to be within normal limits, however, and the urine urobilinogen is low or normal, the presence of extrahepatic obstructive jaundice is more likely.¹¹

In many cases there is a complete overlapping of symptoms, physical findings, and laboratory tests of medical and surgical jaundice. Despite extensive laboratory investigation the physician may be confronted with a dilemma in diagnosis and therapy. To defer surgery in such a patient until the diagnosis becomes more apparent may result in secondary changes in the liver and in the general nutritional status of the patient if an extrahepatic obstruction is present. If, on the other hand, a surgical exploration is attempted in the presence of inflammatory liver disease, such as viral hepatitis, the patient may expire

because of the well-known intolerance in hepatitis to surgical trauma and anesthesia.

A further aid in the diagnosis of difficult cases of this type is the needle biopsy of the liver. This procedure has been used widely in recent years and its indications and contraindications have been clearly defined.^{14, 15} When there is doubt as to diagnosis after a careful clinical and biochemical evaluation, needle biopsy of the liver should be employed. The usual histologic features of viral hepatitis can be separated from those seen in extrahepatic obstructive jaundice with relative ease.¹⁶ Once the diagnosis of acute viral hepatitis is established, however, the liver biopsy can serve no useful purpose in determining the severity or prognosis of the disease. In the later stages of hepatitis, on the other hand, a liver biopsy may prove of great value in establishing the degree and type of pathology which persists.

Special mention should be made of the so-called "cholangiolitic hepatitis" described by Watson and Hoffbauer.¹⁷ These patients show the clinical and biochemical picture of an obstructive jaundice. The liver biopsy in these cases does not show the usual inflammatory changes seen in viral hepatitis but may mimic completely the pathology seen in the liver when obstructive jaundice is present. Surgical exploration may be necessary in such cases for final resolution of the diagnosis.

Treatment

The last decade has seen many remedies attempted and shown to be without value in the treatment of viral hepatitis. The disease is self-limited and usually will take a benign course for a period of thirty to sixty days. Choline, methionine, liver extract,¹⁸ and nonsurgical drainage¹⁹ of the gallbladder have all been attempted with imperceptible success in shortening the course of the disease. Extensive studies have been made with the use of aureomycin²⁰ and terramycin²¹ in acute viral hepatitis and with the exception of one favorable report with the use of terramycin these have not contributed significantly to the management of the disease.

There is a growing general opinion that a conservative regimen of management including adequate bed rest and a nutritious diet administered for at least as long as liver tenderness and positive liver function tests persist provides the

soundest program of therapy.²² It has been repeatedly demonstrated that excessive activity early in the course of viral hepatitis may lead to an unnecessary prolongation of symptoms and findings and may result occasionally in chronic viral hepatitis.¹⁸

The diet offered should be a nutritious one containing at least 150 grams of protein and 3500 calories. It should be attractive and palatable. Since there is some indication that this high intake of food early in the disease will tend to shorten the period of anorexia and nausea, and possibly even the course of disease, the patient should be encouraged by every means available to ingest this diet. No evidence has been produced that fat in the diet has a deleterious effect upon the course of viral hepatitis.²³ Restriction of fat, on the other hand, often makes it exceedingly difficult to achieve a palatable diet and an adequate caloric intake.

Special mention should be made of the use of ACTH in the treatment of acute hepatitis. Several reports of its use in hepatitis and other forms of liver disease have now appeared in the literature but the results have not been dramatic.^{24, 25} In an average case there appears to be some shortening of the duration of jaundice, but this is not significant when one considers the side effects and relapses after withdrawal along with the apparent benefit shown. In the patients with the cholangiolitic type of hepatitis, however, ACTH appears to shorten the course of jaundice materially and probably should be tried in all such cases.

A great deal of interest has been shown recently in the possibility that chronic hepatitis and hepatic cirrhosis may follow an episode of acute viral hepatitis. That there may be a prolongation of symptoms and findings in viral hepatitis for months or years beyond the onset of the disease, has now been established beyond a doubt.²⁶ It is not yet clear what factor or factors are responsible for the production of the chronic disease. Inadequate bed rest in the acute stage, alcohol ingestion, intercurrent infection and older age at onset, as well as a predisposition on the part of the patient, have all been found to be possible contributors to the production of chronic hepatitis.²⁷ It is now the common belief that hepatic cirrhosis can and does result from a previous bout of viral hepatitis but unequivocal evidence

that this can take place is lacking.^{28, 29} Although the presenting features are somewhat variable, the clinical, laboratory and histopathological findings in this condition have been reasonably well defined. Chronic viral hepatitis may be said to be present in a patient who has a history of acute viral hepatitis with symptoms, physical findings or laboratory evidences of hepatic disease which persist or recur for six months or longer after the onset of acute hepatitis. Such a patient should also show abnormal liver pathology at the time of liver biopsy.²⁶ It should be emphasized that this definition is an *etiologic* one which implies that hepatic cirrhosis may be an end stage of chronic viral hepatitis. Results of treatment in such cases have not been dramatic. It has been found that best results can be obtained and the best degree of well-being can be achieved with the use of a diet similar to that used in acute hepatitis along with a period of restricted activity. The prognosis in this group of cases is uncertain. Many undoubtedly recover completely or develop a latent phase of the disease. Others seem to manifest a progressive downhill course.

Prevention

The spread of viral hepatitis has been shown to take place by two principal means: the naturally occurring form of the disease is probably spread mainly through contamination of drinking water and food by a carrier or a patient in the incubation period of hepatitis. The artificially transmitted form of disease is spread through the use of blood and blood products containing the virus of hepatitis.¹⁰ Both whole blood and plasma transfusions are responsible for transmission of this latter type of disease. In the past few years efforts have been underway to inactivate the virus of hepatitis in whole blood and plasma. The principal method employed has been ultraviolet irradiation of pooled plasma.³⁰ That this measure has not been universally successful is borne out by recent reports in the medical literature.^{31, 32, 33, 34} That unsterile syringes, needles, lancets, dental and other surgical instruments can spread viral hepatitis from one patient to another, has also been well demonstrated.¹⁰ The exact role played by such instruments in the over-all incidence of hepatitis has not yet been completely evaluated. It is probably true, how-

ever, that this means of transmission will tend to increase in the future if proper measures for the sterilization of instruments are not adopted. It has been reasonably well shown that chemical or cold sterilization will not destroy the virus of hepatitis. After thorough cleansing, such instruments should be boiled for a minimum of ten minutes and subjected to dry heat (160° C.) for one hour to insure the destruction of the virus.

Recent studies^{35, 36} have pointed to the possible value of gamma globulin as a preventative measure in individuals exposed to the naturally occurring form of viral hepatitis. Although this measure shows great promise of success it must be evaluated in many places and under many circumstances before final conclusions can be drawn.

Summary

Because hepatitis has been found to be a problem of major medical importance in the last ten years, intensive studies have been undertaken to broaden our knowledge of the disease. Definite progress in diagnosis, management and prevention has resulted. The cause of the disease and its biochemical and histological variations have been defined. There has been a growing recognition that the disease may become chronic and result in hepatic cirrhosis. Although no specific therapy has been developed we now have a better comprehension of the proper use of bed rest and diet in management. Careful epidemiological studies have emphasized the many possibilities for spread of hepatitis by food and water contamination, and by day to day medical and dental practices.

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MEDICAL EDUCATION KEEPS AMERICA HEALTHY

The nation's 79 medical schools are the key to the people's health. On them depends the future physical and mental well-being of 157 million people. From their laboratories come the medical discoveries that help make this country the most advanced—the most disease-free—in the world. From their classrooms and teaching hospitals come the family doctor, the specialist, the health officer and industrial physician who translate new medical knowledge into community services. Thus, strong, well-equipped, competently-staffed medical schools are essential to national security and a constantly rising standard of living for all the people.

THE JOURNAL

OF THE

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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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1953 ANNUAL CONVENTION

THE PLANNING for the Annual Convention at French Lick on October 19, 20 and 21 is now well past the preliminary stage. All members of the Association are reminded to make their hotel reservations early.

The first day, Monday, will be devoted to the golf tournament, the trap and skeet shoot and the instructional courses.

The opening meeting of the House of Delegates, as well as the meetings of the Council and Executive Committee will be held on Sunday the 18th, in order to interfere as little as possible with the scientific program and other affairs of the convention.

The scientific program is almost complete, and will be published in full in an early issue of THE JOURNAL.

One of the most important subjects, that of poliomyelitis, will be covered by several papers by well known authorities. Other clinical problems such as Corticoid Therapy in Dermatology,

Cardiac Arrest, Thrombo-embolic Diseases and Functional Bleeding will be discussed on the general program.

Each of the clinical sections of the Association will present a scientific program on Wednesday afternoon. The Section on General Practice will listen to a down-to-earth practical subject entitled "Doctors and Dollars" presented by Allison E. Skaggs of Battle Creek, Michigan. Mr. Skaggs is renowned for his discussions of the various aspects of the physician's economic problems.

Ample intermissions in the program are allotted for the viewing of the scientific and technical exhibits. The technical exhibit for 1953 promises to be the best and largest of any of the French Lick meetings. Technical exhibitors were well pleased with their reception at the 1952 convention and are preparing to exhibit and explain many advances in the therapeutic field. Special prizes have been devised for those physicians who pursue this part of their postgraduate training most diligently.

HOOSIERS AT THE A.M.A.

WHEN THIS is published the American Medical Association will be meeting in New York City for its 106th Annual Session. The meeting has been planned with the expectation of the largest registration in the history of the A.M.A.

The program of the Scientific Assembly includes several Indiana physicians who will read papers before the various sections.

Robert E. Holsinger and John E. Dalton of Indianapolis will present the subject of "Isonicotinyl-Hydrazine in the Treatment of Cutaneous Tuberculosis and Allied Conditions" to the Section on Dermatology and Syphilology.

Theodore F. Schlaegel, Jr. and Louis N. Hungerford of Indianapolis will talk to the Section on Ophthalmology on "Isonicotinic Acid Hydrazide in Ophthalmology" and Doctor Schlaegel and Fred M. Wilson, Indianapolis, will present a paper on "Experimental Granulomatous Uveitis: Studies on the Mechanism of the Contralateral Reaction after the Use of Horse Serum in Rabbits."

J. A. Campbell and David C. Gastineau of Indianapolis will read a paper on "Specificity of Roentgen Findings in Suppurative Pneumonia of Infants and Children" before the Section on

Pediatrics and also to the Section on Radiology.

Carl F. Huber of Indianapolis will participate in a "Symposium on Prevention of Needless Neonatal Deaths" before the Section on Pediatrics. His subject will be presented from the viewpoint of the obstetrician.

Lall G. Montgomery of Muncie is Chairman of the Section on Pathology and Physiology and in that capacity will present an address on "Medical Technology and Its Relation to Physiology and Pathology."

Three Indianapolis doctors are members of the Executive Committees of their respective sections: Lester Bibler, Section on General Practice; Carl H. McCaskey, Section on Laryngology, Otology and Rhinology; and Robert J. Masters, Section on Ophthalmology.

The Scientific Exhibit presented "by doctors for doctors" also will find several Hoosier physicians participating. Doctor Montgomery will serve on the Advisory Committee for the Special Exhibit on Fresh Pathology and will have an exhibit on Certification of Medical Technologists.

M. L. Bankoff and B. M. Kohrman, Clinic Associates, Michigan City, will have an exhibit on Treatment of Symptoms—A Study of Relief of Pain in Psychosomatic Syndromes.

TRAFFIC SAFETY MONTH IN INDIANA

AUTO accidents and fatalities in the United States have increased each year for the last three years. In 1952 the toll of injuries and death reached a new record high—the worst in history. 37,600 deaths and 2,090,000 injuries is a staggering toll when one considers that almost all auto accidents are preventable. Accidents don't happen, they are made.

The Travelers Book of Street and Highway

* Copies may be obtained, as long as the supply lasts, from The Travelers Insurance Companies or their representatives.

Accident Data* is published each year by The Travelers Insurance Companies to highlight the statistics of highway slaughter. The booklet is illustrated by cartoons which this year back up the statistics to indicate more clearly than ever that the guilty party is THE DRIVER.

Prominent facts in the national picture for 1952 were:

1. Three out of four accidents involved passenger cars traveling in clear weather on dry roads.
2. Nine out of ten vehicles in accidents were

in apparently good condition before they crashed.

3. Eighty per cent of vehicles involved in fatal accidents were traveling straight ahead.
4. Saturday was the most dangerous day of the week to drive.
5. Young drivers were involved in almost 25 per cent of the year's fatal accidents.

The situation is no different in Indiana. Governor George N. Craig in launching Traffic Safety Month in May, stated that engineers were eliminating dangerous curves and bridges as expeditiously as possible but that this necessary work would not eliminate the accident problem.

"Nearly 60 per cent of all the rural fatalities occurred, not at these so-called danger sites, but on straight and level road where prudence and

judgment and not a \$3,000,000,000 highway program might have avoided the tragedies.

"Of the 796 lives lost in rural accidents last year 455 took place in localities where more funds and more construction would have done no good."

It's the old story of 100 horsepower machines with one horsepower brains doing the driving.

The traffic safety program of the Indiana State Police consists of a constant crusade with emphasis on control of traffic on the relatively few stretches of the state road system which experience has shown are the most productive of accidents.

Better driving is the only practical means of lowering highway fatalities. Education and traffic control programs must be pushed to accomplish this as soon as possible.

VOLUNTARY PENSION PLANS

DURING the first week of the 83d Congress bills were again introduced to permit tax deferments on amounts used to purchase retirement annuities. These measures, H.R. 10 and H.R. 11, which were introduced by Mr. Jenkins of Ohio and Mr. Keogh of New York, are identical with the "Keogh-Reed" bills of the 82d Congress. The bills are designed to encourage the establishment of voluntary pension plans by individuals and to provide more equitable tax treatment for self-employed persons. The bills in their present form now include all the amendments suggested by the American Medical Association at hearings on the original legislation last May.

Through amendment of the Federal Internal Revenue Code, the bills would allow physicians and other self-employed individuals to deduct from their taxable income those amounts used each year to finance restricted retirement plans. Employed persons not covered by existing pension plans also would qualify for the tax deduction privilege.

Income received later during the years of retirement, either from pension funds or insurance annuities, would then be taxable under the

prevailing rates. In other words, they provide tax deferment but not tax avoidance.

Physicians, dentists, lawyers, architects, farmers, store owners and the many others who comprise the nation's self-employed have long been neglected in federal tax legislation relating to pensions. The purpose of these bills is to eliminate the discrimination and inequities existing under present tax laws. By extending the tax deferment privilege to the country's ten million self-employed, and also to millions of employees who are not covered by pension plans, this new legislation will give them the incentive to save for old age during their best earning years.

Under Section 165 (a) of the 1942 Revenue Act, millions of employees covered by more than 16,000 approved pension plans are already receiving the benefit of pension tax deferment. They pay no tax during their working years on the employer's contribution to their retirement fund, even though it actually is extra compensation to the employee. After he retires, however, the employee must pay the tax on the part of the retirement benefit which was financed by the employer.

To provide a similar tax arrangement for self-employed persons, the bills would allow annual deductions of 10 percent of earned net income, or \$7,500, whichever is smaller. Total deductions during a taxpayer's lifetime could not exceed \$150,000. The funds excluded from taxable income would have to be paid either to a trust fund established by an association for the benefit of its members or to an insurance company as premiums for a retirement annuity contract. In either case, no income payments or cash refunds could be made before the age of 65 except in cases of total disability or death.

The bills include a provision enabling persons already between the ages of 55 and 75 to make larger annual deductions than the basic 10 percent or \$7,500. This is a practical equivalent to the past service credits allowed in many employee pension plans. The bills

also provide for a carry-over of unused deductions for a period up to five years. This is designed to give—equitable treatment to persons with extreme fluctuations in income.

This legislation will be of particular benefit to physicians who go through a long and costly period of training and whose peak earnings are bunched into a comparatively short period of years when they are subject to high income tax rates.

This legislation, which has the approval of the American Medical Association and twenty other national organizations, can be enacted by the 83rd Congress if physicians and all other self-employed persons work actively together for its passage.

—A.M.A. Bureau of Medical
Economic Research
March 30, 1953.

Letter to the Editor

May 8, 1953

The Journal of the

Indiana State Medical Association
1017 Hume Mansur Building
Indianapolis 4, Indiana

Dear Sir:

The Executive Committee Council of the Indiana Association of Pathologists requests that the enclosed copy of a letter, to the co-chairman on the Committee on Public Policy of the Indiana State Medical Association, be published in the Journal in order that the members of the profession be informed as to the stand taken by the Indiana Association of Pathologists regarding the performance of premarital serologic tests by the Indiana State Board of Health for a fee.

Very truly yours,
Joseph L. Haymond, M.D.
Secretary-Treasurer
Indiana Association of
Pathologists

Text of the above mentioned letter follows:

February 25, 1953

Dear Doctors:

The attention of the Executive Council of the Indiana

Association of Pathologists has been called to Senate Bill 205, page 52, lines 10 through 16, in which provision is made for the performance of premarital serologic tests by the Indiana State Board of Health Laboratory for a fee.

We have seriously considered this provision, and we feel that your approval of this paragraph was undoubtedly motivated by your sincere concern for the best interests of medicine. We believe, however, that the performance of laboratory examinations by the State Board of Health for a fee constitutes the practice of medicine by a State agency.

It is true that this proposed bill as now constituted would affect an increased financial gain for the Pathologists. However, we are concerned with the more fundamental issue as stated above. Such a provision might lead to the unlimited expansion of and the intrusion into the practice of medicine by a State agency. We, therefore, recommend that this provision be deleted from the bill.

For the Executive Council:

J. L. Haymond, M.D., Chairman
James M. McFadden, M.D.
David Adler, M.D.
Carl Culbertson, M.D.
David Rosenbaum, M.D.
J. L. Arbogast, M. D.

Very truly yours,

J. L. Haymond, M.D.
Secretary-Treasurer

Medical Panorama *by the* ASSOCIATE EDITOR

CHECK YOURSELF ON THIS POINT

Dr. Robert C. Combs, Assistant Secretary-Treasurer of the San Francisco Medical Society has written an editorial in that society's *Bulletin*, March 1953, entitled "Inform the Patient!" in which he calls attention to a laxity on the part of some physicians in being sure the patient understands his condition and medical or surgical findings. No doubt we all err at times in this respect owing most often to press of other work. But Dr. Combs' ideas are worth a perusal, and the main portion of his editorial follows:

We have all, at some time or another, been dismayed and surprised by a patient's inability to give us vital information about his past medical difficulties. This is frequently due to the patient's inattentiveness, or poor memory, occasioned by his emotional upset at the time of observation, but, on the other hand, it may be due to failure on the part of a previous physician to explain to the patient just what was found, and to point out to him future possible implications. * * * This is even more important in these days when, because of extensive travel, frequent changes in residence, and medical specialization, a patient sees many physicians during a lifetime and his old records often are not readily available. * * * a large segment of our public is becoming increasingly familiar with medical terminology and concepts, and to a fair degree, keeps abreast of developments through the publicity given medical advances in the public press, radio, TV, and the like. These people are more and more often demanding the explanations to which they are entitled, and indeed are better able to retain this information for future use.

The practice of medicine is still an art and naturally, at times, one's own good judgment will determine that certain facts be withheld. However, the following are but a few examples of that which should be told: The parents, our own files, and later the child must have an accurate record of his immunizations. A patient exhibiting a drug sensitivity should be cautioned about the dangers of future contact, and possible sources, perhaps obscure ones, of the drug in question pointed out. It would be well for all civilians, as well as military personnel, to know their blood type and Rh factor, if it has been determined. X-rays taken for one purpose often disclose unrelated conditions such as malrotation of the colon, diverticulitis, healed Tbc., etc. The patient should know of these observations. The gynecologist must leave no doubt in the patient's mind as to whether or not the vermiform appendix was removed. Family history is still important. Even though the patient may have died, our duty to the remaining family requires us to inform them of the possible hereditary or familial nature of any condition found.

The point regarding modern travel and changes of residence is well taken, but just as important is the one of lacking of understanding on the part of the patient because he happens to be emotionally upset at the time the information concerning his condition is imparted. In surgical cases, the patient should be told about his operation several days later to be certain he is not under such a "hang-over" from his anesthetic or other narcosis as to be unable to comprehend or remember the doctor's words. In our experience, this effort is one "service" which patients do appreciate.



The five-year-old son of a psychoanalyst was asked what he was going to be when he grew up—and he unhesitatingly gave a very straightforward answer—unblemished by juvenile jargon, "I wantta be a patient."



President's Page



FELLOW MEMBERS OF I.S.M.A.:

MOST general hospitals employ the "means test" before admitting a patient unless the patient presents an emergency condition. If they did not exercise the prerogative of checking the patient's ability to pay, hospitals would soon bog down with debt and inefficiency in operation. In Indiana tuberculosis sanatoria are obligated by law to request patients or their relatives to pay according to income for the patient's care. Their superintendents are obligated to obey this law and if they become guilty of heterodoxy, they should be relieved of their command. Many social workers wish to adopt the course of least resistance and advocate that the "means test" interferes with tuberculosis control. They have been misinformed and, too often, have discarded it as a policy. In so doing they are undermining American tradition and the education for its use which the general hospital is trying to inculcate in the mind of the public.

In the mental hospitals of Indiana, every patient, relative, or trustee must pay \$10.00 a week maintenance charge. If the patient or relative cannot pay, the trustee investigates and decides whether he or the patient's relatives should pay the \$10.00, fixed by law. The application of any "means test" requires extra work but it can be performed by those who are already on the trustee's or hospital's payroll.

Instead of talking about the indignities of the "means test" upon which the hospitals depend for existence, we should educate the public about the dignity of the "means test". We can teach people to apply it properly on any case, even of tuberculosis. All those concerned, health officer, trustee, tuberculosis association, can concentrate upon the epidemiological implications of the law when the patient is first approached. After the patient is admitted to the sanatorium, the fiscal aspects of the case can be investigated.

A medical indigent may be classified as a person who is in need of care and treatment which neither he nor his relatives can purchase without depriving themselves of the necessities of life. Of course, the W.P.A. instigated the idea that movies, tobacco, cosmetics, and lingerie were necessities of life and nowadays it is difficult to revert to those necessities of life which were designated by the name of blue denim, sow belly, and beans. A chronic disease soon exhausts personal resources and if the entire financial obligations of an extended illness were met, the family of the patient would be overburdened with debt. In view of this, the department of public welfare utilizes the "means test" to determine the eligibility of those who require shelter, food, clothing, and medical care. If they did not practice this type of investigation, in the course of time 30 million people might be working to take care of 60 million.

If a tuberculosis hospital did not enforce the "means test" many patients would sponge off the taxpayer just as the following case report depicts. A private physician referred this male patient, age 29. Four weeks after he was admitted to the hospital, his mother asked if there were extra charges for the first month which his insurance did not cover—as she wanted to go to the

Trustee's office to seek payment for any extras. She was informed that a daily rate beyond insurance had not as yet been established, and that the patient had been charged only for streptomycin to date. The following day the Trustee called the hospital and said the Mother had applied for assistance to pay her son's medication bill. The Trustee reported that the boy was buying two cars, one a Nash Rambler on which he was paying \$82.65 a month, and a Chevrolet at \$48.00 a month. The father averaged \$61.00 a week net, with no one to support but his wife. The family is buying a home through the F.H.A. at \$50.00 a month and also has a television set. Thus the "means test" not only saved the taxpayers' money but it was applied after the patient was admitted, which counteracts the only argument of any merit against the "means test". How can you, as a taxpayer, disapprove of such or similar measures?

The money collected from relatives who have patients in mental institutions is placed in a special fund for the hospital. The money collected from patients and relatives in tuberculosis institutions is returned to the tuberculosis hospital's general fund and re-appropriated only for the hospital's use. Until six years ago, when the legislature changed the law, it transferred to general county expense.

Never should tax funds be expended for those who can help themselves, and tax money should be judiciously expended on those who can pay part of their expenses. The patient, under such a policy, will not only be a better patient, but his relatives will assume more interest if they assume part of the expense. Sad but true, Mr. and Mrs. Public can be educated to whatever plan or policy you desire to follow, namely, the one which flirts with socialism or to the one which a system of free enterprise investigates. The "means test" encourages citizens to become self-reliant and irreproachable about their frugality and economic independence. Every medical organization and lay-health organization in the United States, if it so desires, can do much to stamp out the philosophy of many social workers, who should apologize to the Twenty-Third Psalm, when they, perhaps inadvertently, teach that "The State Is My Shepherd, I Shall Not Want". The abolition of the "means test" contributes to this philosophy.

Paul D. Grimm M.D.

P. S. "The end (American self-reliance) justifies the means (test)".



ANONYMOUS poem often misquoted:

Three faces wears the doctor: when first sought
An Angel's; and a god's the cure half-wrought;
But when, the cure complete, he seeks his fee,
The Devil looks less terrible than he.

—*San Francisco Bulletin.*

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

HELPING THE NATION'S HEALTH

Another volume of the Truman Commission on the Health Needs of the Nation is off the Government presses. This one is Volume V, and it is the second to appear. Volumes II, III and IV are not yet ready because, it is explained, they contain graphs and charts which take longer to prepare than just words.

The new volume is entitled "The People Speak," and it includes statements from about 400 witnesses testifying to the difficulties of paying medical costs in cases of serious or protracted illnesses, a situation a lot of us know the tragic implications of first hand, and one which only the most heartless would not want something done about. Both Mr. Truman and his recent Federal Security Administrator, Mr. Oscar Ewing, thought the Federal Government ought to assume the responsibility for the health of the nation. What they proposed was an intricate form of socialized medicine which would have placed a burgeoning bureaucracy atop the medical profession, and which would have vastly increased the tax burden of everyone.

Federal aid is included in the recommendations of the present commission also, through voluntary insurance backed by state funds. But this, too, is subject to the same sort of criticism socialized medicine has met. For there must be a bureaucracy and there must be added taxes to support state, Federal and voluntary medical cost plans.

It seems to us that most of the approaches to this problem of individual medical care are all the wrong approaches. For what they all necessitate is more and more Government intervention and more and more taxes. The Federal Government can help a lot in the medical problems of people, but it can help best by less intervention.

It can do this by allowing taxpayers to deduct costs of every visit to the doctor, the dentist, and hospital and for medicines. Nearly everyone these days is a taxpayer, and instead of compounding their taxes to provide services everyone at some time or other needs, the Government can accomplish practically the same purpose by allowing the people to subtract those costs from their taxes. In hardship cases the Government might even allow the deductions over a period of years, or even adopt a system of "carry forward and carry back" so that taxes might be placed in balance with catastrophic medical costs and in some cases re-

turned to taxpayers to help them with their bills. Not all cases, of course, would fit such patterns.

It is not wise for the Federal Government to foot the bill for individual medical care. But what it can and ought to do is to quit taxing the individual for trying to stay healthy.—*Wall Street Journal*.

BRITAIN'S HEALTH SERVICE

Varying reports come to this country about the experience of the United Kingdom with socialized medicine. Evaluations here are extremely difficult because of differences in standards and practices. It is now obvious, at any rate, that after an experience of five years Britain will retain its nationwide health service. Ian Macleod, Minister of Health in the Conservative Government, is talking these days about benefits from the system and he is saying nothing about any basic shortcomings of the plan. Thus, presumably, he is indicating that Prime Minister Churchill has no intention of challenging the policy that Laborites made effective in 1948.

Opinion surveys indicate that the great majority of British people approve the plan. Health standards, especially, as regards women, have improved according to the health minister. Ninety-seven per cent of the people are being treated by doctors paid in large part by the government. The other 3 per cent, presumably well to do, are cared for by the 500 of the nation's 20,000 doctors who remain in private practice. In recent adjustments of payments, doctors have been given more and dentists less.

As might be assumed, it is possible to get almost any kind of opinion on the system. The remark is made that penicillin and other new drugs are far more responsible for health betterment than socialized medicine. Most doctors, professionally, are still opposed. New hospitals, under public financing, are not being built as had been expected although many are being enlarged.

As for quality of the service, medical men for the most part are not claiming any great achievements, neither are they conceding that their individual performance has suffered.

It would be difficult to say what the implications are so far as future policy for the United States is concerned. Average health service in this country is somewhat better than it is in Britain. All who

need attention in Britain can get it readily. That claim can hardly be made in this country and the need for service on a broader scale is a problem that must be faced speedily.

The United States shows a determination to avoid socialized medicine but we must face the fact that there are millions who because of distance or

finances, cannot obtain the care and treatment they require. We may be able to learn some things from Britain's experience that will help in our own efforts to improve facilities and to lower, if possible, the bills for illness at a time when those totals are too much of a burden on budgets of most American homes.—*The Hartford (Conn.) Times.*

VANDEBURGH COUNTY DOCTORS JOIN PRESS IN PRESENTING FALL FORUM

FREE PUBLIC medical forums each Sunday evening next October and November in Evansville are being planned as the result of a vote of approval by the Vanderburgh County Medical Society at their April 14 meeting. The series will be a joint undertaking of the medical society and the Evansville Press.

Modeled after the original Pinellas County Medical Society plan which was inaugurated at St. Petersburg, Florida, several years ago the Evansville Medical forum series is being arranged by the Vanderburgh County Medical Society board, the society's public relations committee and the Press.

Dr. E. L. Fitzsimmons, president of the society, and Dr. L. Edward Gaul, chairman of the public relations committee, believe the project is a great step forward in public medical education.

The St. Petersburg forum plan has been adopted in several other cities, including Atlanta, Georgia, and Dayton, Ohio. In each city the meetings have drawn overflow

crowds. Success of the public forums between local physicians and interested citizens has attracted editorial comment in national publications.

The plan is simply this—subjects of interest to the public will be selected from request coupons clipped from the Press, a panel of four local doctors will serve at each meeting with discussion being supervised by a moderator. Topics and questions submitted through the newspaper will be handled by the panel members and ample time will be allowed for preparation of this material by the participating doctors. A different group will serve on the panel at each successive forum. Doctor Gaul is now contacting all doctors in the area and society officers are predicting almost 100 per cent participation.

"Where the forum idea has been tried," Doctor Fitzsimmons said, "it has helped to dispel many of the misunderstandings about common ailments. It has helped people to detect and identify their own illnesses and has shown them what to do to effect cure."



A.M.A. RECOMMENDS THREE MAJOR CHANGES IN DOCTOR-DRAFT LAW

LEGISLATION now pending (S. 1531 and HR 4495, 83rd Congress) to extend the doctor draft law until July 1, 1955, differs considerably from the bill originally prepared by the Department of Defense. The AMA is primarily concerned over three important facets of these measures. (1) The availability of a sufficient number of physicians in priorities 1, 2 and 3 to satisfy the requirements of the armed services for the next several years obviates the necessity for registry and calling into the armed forces physicians with previous military service. The AMA, therefore, has recommended that registrants or reservists falling within the definition of priority 4, be excused from any further liability under the doctor draft law. (2) The proposed two-year extension of the law. The AMA recommends that any continuation of the law be limited to one year in the belief that compulsory legislation may no longer be necessary after July 1, 1954. (3) It has been recommended that the special pay of \$100 per month currently payable to physicians and dentists in the armed forces be limited to those persons who volunteer for active duty in excess of 24 months. The AMA believes that this \$100 additional payment is justified and that its termination would drastically impair the medical corps' ability to attract volunteers.

The new bill reenacts the language of the present law with a few additions. In brief, the bill would:

- (a) Define "active duty" and "active service" to include enlisted or commissioned service since Sept. 16, 1940, with the exception of time spent in special educational and training programs.
- (b) Give credit for time spent in work of national importance by conscientious objectors during World War II.
- (c) Recognize service between Sept. 16, 1940, and Sept. 2, 1945, in the armed services of any allied country.
- (d) Exclude from liability for further duty physicians with 12 or more months of service since June 25, 1950. Distinction is made between service in World War II and service since June 24, 1950.
- (e) Authorize the commissioning of non-citizens.
- (f) Renew the authority of national, state and local medical advisory committees to the Selective Service System.
- (g) Authorize the appointment or commissioning of medical officers in grades "commensurate with professional education, experience or ability."
- (h) Terminate automatically reserve commissions of all physicians taken into service upon completion of 24 months duty.
- (i) Continue, until July 1, 1955, the authority of the President to order members of the reserves to active duty with, or without their consent.
- (j) Limit to 17 months the tour of duty of members of the reserves ordered to active duty provided they had 12 or more months of service since Sept. 16, 1940.



INDIANA EXTENDS WELCOME TO NEW DOCTORS IN PROSPECTUS

"A PLACE of Your Own Is Awaiting You in Indiana," the Indiana State Medical Association is telling doctors and graduating medical students who inquire about locations. The brochure, bearing the above title, contains a warm letter of welcome, telling of the many virtues of Indiana.

Then follows a comprehensive picture of the overall medical and hospital situation in the state and specific openings.

A map of Indiana shows at a glance the number, type and capacity of hospitals in each county and the population per physician as based on the last official census.

All licensed hospitals are listed next, with correct name, location, whether county or non-profit corporation, whether general or specialized, and the number of beds and bassinets.

Currently the brochure contains maps of 17 counties where 22 doctors are needed. The maps give 1940 and 1950 census figures, names of towns and populations and number of physicians. Following each map is a survey on community resources and physician needs with complete data concerning the town or city seeking a doctor. Few questions will be left unanswered when a prospective new doctor has read the fact sheet about the community or communities in which he may be interested.

A reprint, "Rural Practice Can Be Fun", from the Student American Medical Association Journal is included. In this, John R. Rodger, M.D., who practices at Bellaire, Michigan, asks and answers many questions which arise about small town practice and a summation shows the pros exceeding the cons.



*"A PLACE OF YOUR OWN"
IS AWAITING YOU IN INDIANA*

Pictured above is a reproduction of the cover for a booklet now being mailed by I.S.M.A. headquarters to doctors and students seeking information about communities having a doctor shortage. To personalize the brochure, the doctor's name is imprinted on the house marker near the fence.

There is an official highway map of the State of Indiana in each brochure that goes out in response to an inquiry about openings for doctors and for the doctor who may not care to use available office quarters and where none are available, suggested floor plans for doctors' offices and clinics together with estimated cost of construction are included. These plans were selected in a recent contest sponsored by the Indiana Association of Architects.

To complete the service, a postal card is attached to the inside cover for use when a physician selects a community in which he intends to begin practice. He is asked to

inform the Physician Placement Service of the Indiana State Medical Association of his choice so the community will not be suggested to others.

Each copy of "A Place of Your Own Is Awaiting You in Indiana" will carry the name of the investigating doctor to whom it is mailed on the cover.

At this time, "R. U. Prospect, M.D." may choose a location almost anywhere in the small town and rural areas near the state borders on the north, south, east or west. He may select a little town on the Ohio River of 100 population where the nearest doctor is 14 miles away or a southwestern Indiana city of 6,150 where the doctors are overworked; he may go into the rich farmland of the northwestern section of the state below

the Calumet area, into the mining districts, the dairyland of the northeast part of the state, in fact, a good doctor can earn a good living, own a modern home and prosper while serving humanity in dozens of available locations in the state.

The prospectus has been assembled by the Rural Health Committee of the Indiana State Medical Association with the Assistance of James A. Waggener, executive secretary.

The Council on Medical Services of the American Medical Association has requested copies of the Indiana brochure, which is in loose leaf form to permit deletions and additions, for their exhibit at the Annual Meeting of the American Medical Association in New York, June 1-5.

BLUE CROSS "BANK" ASSURES HOSPITALIZATION FOR TRAVELERS

MORE THAN 470,000 Blue Cross subscribers who have been hospitalized while traveling have received hospital service benefits through Blue Cross Plans other than their own, it was announced recently at the 1953 Annual Conference of Blue Cross Plans. This has been made possible by a mechanism called the Inter-Plan Service Benefit Bank, an agreement among the Plans under which they furnish reciprocal benefits to one another's members. Total hospital care purchased for members in this way has amounted to \$46,000,000 to date.

These figures cover the three and one-half years since the "Bank" has been in operation, it was explained. Inaugurated in 1949 as an experimental project, the program has proved to be a workable instrument for providing service benefits to subscribers of one Plan when hospitalized in a member-hospital of another Plan.

Formerly, if a subscriber entered a hospital outside of his own Plan's area, he usually received only a fixed daily cash indemnity. Now he receives the complete benefits, in terms of hospital services, of the Plan in whose area he is hos-

pitalized. This reciprocal agreement among the Plans was entered into voluntarily, each Blue Cross Plan being an entirely independent local organization.

The 470,000 cases represent 3,450,000 days of patient-care. Use of the "Bank" has grown steadily; the number of cases handled in 1952 represented a 30 per cent increase over the previous year. Benefits last year totalled \$19,500,000.

The "Bank" is a clearing-house operation, managed in Chicago by the Blue Cross Commission of the American Hospital Association. The procedure in handling a case is a simple one: When a member of the Florida Blue Cross Plan, for example, is hospitalized in New York City, the hospital notifies the New York Blue Cross Plan, which pays the hospital for the member's care according to its own benefit schedule. The Bank office in Chicago then reimburses New York and charges Florida. Efficiency of operation is indicated by the fact that operating expense of the Bank in 1952 was only one fifth of one per cent of total funds handled.

YOU CAN'T TAKE IT WITH YOU!

The familiar saying "You Can't Take It With You" is probably older than your great-great grandfather, but it is just as true now as yesterday. Once used only in connection with money, this proverb now refers to Blood, for you can't take *it* with you either. Everyone is affected by this expression, for, rich or poor, everyone has blood.

Every day hundreds of people depend on blood for their lives. In Korea our fighting men need blood every hour of the day and night. Here at home, accident and disease victims require blood in never ceasing quantities. Gamma Globulin, the disease fighting derivative of blood, is in action every day aiding grownups and children alike. Emergency blood reserves being built up by Civil Defense will help save lives . . . perhaps your very own . . . in case of an attack on this country.

Yes, you certainly can do a lot of good with a little of your blood. All it will cost you is a few minutes of your time. Give a pint today, for tomorrow may be too late to help someone live. Nothing can quite equal the satisfaction you will feel when you give your blood to help fill our country's needs. It's the kind of satisfaction that money can't buy.

Call your local Red Cross, Community or Armed Forces Blood Donor Center today to schedule your donation. It's wonderful to feel that deep-down glow of contentment in giving blood. Now is the time . . . you can't take it with you!

Deaths

Will W. Holmes, M.D., Logansport physician for 40 years, died in Memorial Hospital, Logansport, April 28, one week after suffering a heart attack. Born in Fairland in 1888, Doctor Holmes was graduated from Indiana University School of Medicine in 1913. He was a veteran of both World Wars, being released with the rank of colonel from World War II.

At the time of his death Doctor Holmes was president-elect of the Indiana Academy of Ophthalmology and Otolaryngology. He was a specialist in otology, laryngology and rhinology, certified by the American Board of Otolaryngology. Doctor Holmes had been an active member of county, state and national medical societies. He served the Indiana State Medical Association at various times as a member of the Committee on Graduate Education, the Medical Economics Committee and the Committee on Veterans Affairs and Rehabilitation.

Asher D. Huff, M.D., 55, former Grant County coroner, died April 17 in his automobile while enroute to make house calls in Marion. The Marion doctor's death was caused by coronary occlusion. He was attempting to give himself a hypodermic injection at the time of the attack. Doctor Huff had been in ill health for two years. A native of Grant county, he was graduated from Indiana University and for a number of years served as a commercial chemist, later teaching chemistry in Marion High school before reentering Indiana University to graduate from the School of Medicine in 1932. Doctor Huff was a veteran, a member of Grant County Medical Society, the Indiana State and American Medical Associations.

Waldo E. Smith, M.D., 81, who had been a practicing physician at Decatur from 1906 until March 28, 1953, when he suffered a cerebral hemorrhage, died in Adams County Memorial Hospital April 9. A native of Ohio, Doctor Smith came to Indiana originally to teach in Adams County schools but returned to Ohio to

graduate from Ohio Medical University, Columbus, in 1906. He had served as plant physician for a large Decatur industry for 32 years. Doctor Smith was a member of Adams County Medical Society, the Indiana State and American Medical Associations. He was the father of Dr. Lowell C. Smith, West Lafayette.

Curtis R. Hoffman, M.D., 58, died suddenly April 22 in Richmond where he had practiced medicine since 1926. Doctor Hoffman was a native of Franklin county and a graduate of Indiana University School of Medicine in 1925, establishing his practice in Richmond the following year. He was a member of Wayne County Medical Society, the Indiana State and American Medical Associations.

Suffering a fatal heart attack, **James J. Hoover, M.D.**, 70, died April 21 in the Terre Haute sanatorium he founded. Doctor Hoover was a native of Tennessee, a graduate of Meharry Medical College, Nashville, in 1908 and had been a practicing physician in Terre Haute since 1923. Five years later he established the Hoover Sanatorium. He was serving as president of the city board of health at the time of his death and had previously been vice-president of the board of trustees of Central State Hospital, Indianapolis, and a lecturer for 10 years for the Indiana State Board of Health. Doctor Hoover was also active in civic undertakings, having spearheaded a drive for the building in 1946 of a recreation hall and auditorium for Terre Haute youth. He was a member of Vigo County Medical Society, the Terre Haute Academy of Medicine, the Indiana State and American Medical Associations.

John E. Dailey, M.D., former Terre Haute physician, who had been living in Indianapolis for the last three years, where he was in charge of the medical department at LaRue Carter Hospital, died April 20 in his home. He had been in ill health for two years but had been

active until several days before his death. Doctor Dailey, who was 59, was a native of Terre Haute, received his medical degree at St. Louis University School of Medicine in 1920 after serving in the army during World War I. He served a year's internship at St. Luke's Hospital, St. Louis and his residency at St. Vincent's, Indianapolis, before establishing his practice in Terre Haute in 1921. Doctor Dailey was a member of Vigo County Medical Society, of which he was vice president in 1937, the Indianapolis Medical Society, Indiana State and American Medical Associations, International College of Surgeons and the American Academy of General Practitioners.

Arvine E. Mozingo, M.D., Indianapolis physician, noted for his development of a closed method of treating empyema, thus lowering the death rate from influenza during World War I, died April 24 in Robert W. Long Hospital, Indianapolis. Doctor Mozingo was born in Tipton county in 1880, was graduated from Indiana University School of Medicine in 1913, then served his internship at Metropolitan Hospital, New York. He served in the Medical Corps during World War I as a major. Most of his service was at Walter Reed Hospital, Washington, where he developed his empyema treatment.

Returning to Indianapolis after the war, Doctor Mozingo established an office for the general practice of medicine on the South Side and had continued in that location for more than 30 years. He was also known in that area as an obstetrician. He was a member of Indianapolis Medical Society and the state and national medical associations.

Robert H. Wagoner, M.D., 79, died April 29 in his home in Colburn. Doctor Wagoner completed 47 years of practice in that community in 1950 and had been in retirement since. Born in Carroll county, he taught school there after graduation from college and then entered Indiana Medical College at Indianapolis from which he was graduated in 1903. He established his practice in Colburn in July of that year. During World War I he served as a lieutenant in the army. He was a past president of the Tippecanoe County Medical Society and member of the staffs of both Lafayette hospitals, a member

of Indiana State and American Medical Associations.

Stanley M. Cotton, M.D., who had been the only physician in Goldsmith, Tipton county, for 47 years, died on April 9 after suffering a cerebral hemorrhage in his office a few hours earlier. A patient called medical help and Doctor Cotton was taken to Tipton Memorial Hospital where his death occurred. Born in Switzerland county, Doctor Cotton went to Goldsmith in 1902 as a pharmacist, bought the pharmacy, completed his medical training at the Indiana Medical College, Indianapolis, in 1905 and returned to Goldsmith where he had remained since. Late in 1952 Goldsmith celebrated Doctor Cotton Day when 3,500 friends visited the town of 200 to pay tribute to the physician who had, among other things, delivered 4,467 babies.

The veteran physician served at one time as secretary of Tipton County Medical Society, was a member of the Committee on Indigent Medical Care of the Indiana State Medical Association in 1948 and was a member of the American Medical Association.

Lewis A. E. Storch, M.D., 84, retired Indianapolis physician, died May 11 in his home. Doctor Storch, a native of Wayne county, was graduated from the Medical College of Indiana in 1891, and later became senior house physician at the old City Hospital, Indianapolis. He was in private practice for many years. Doctor Storch was a Fifty Year Club member of the Indiana State Medical Association.

Thompson R. Rice, M.D., 89, died May 9 in St. Mary's Hospital, Evansville. He was one of southern Indiana's oldest practicing physicians, having opened his office for the general practice of medicine in Petersburg in 1892, the same year he was graduated from Hahnemann Medical College and Hospital of Philadelphia. He had been in the Petersburg community since. Doctor Rice was a member of Pike County Medical Society, a senior member of Indiana State Medical Association and associate member of American Medical Association.

News Notes

Hoosier GP Honored At WMA Conference



George R. Daniels, M.D., Marion general practitioner for the last 53 years, is pictured above, right, with Frank L. Chenault, M.D., Decatur, Alabama, just after the two 75-year-old doctors, with 46 others representing each state, were recognized as guests of honor at the First Western Hemisphere Conference of the World Medical Association at Richmond, Virginia. Theme of the April 21-25 conference was medicine's achievements in lengthening life and improving health.

Doctor Daniels not only has on record 53 years of service to his patients but has served the medical profession for 40 years, beginning with his first office, secretary of Grant County Medical Society, in 1913. In 1919 he became a member of an Indiana State Medical Association committee and has been active almost continuously since. He was President of the state association in 1928, has served on the Budget Committee many times, and was a member of the Public Policy and Legislation Committee for almost 20 years.

He has also been active politically, serving as Marion city health officer, mayor of that city and county coroner for several terms. He now holds that office.

Doctor Daniels is a third generation physician. His father, Dr. G. W. Daniels, practiced in Sweetser, and his grandfather, Dr. Edward Daniels, began the practice of medicine in St. Paul, Indiana, in 1857.

Dr. George J. Garceau, Indianapolis, was one of the speakers at the May 5 and 6 regional meeting of the Great Lakes Division of the United States Chapter of the International College of Surgeons in Chicago. Doctor Garceau's paper was "Classification and Treatment of Fractures of the Neck of the Femur."

The 72nd Annual Convention of the **Indiana Pharmaceutical Association** will be held in the Claypool Hotel, Indianapolis, on June 16, 17 and 18.

Dr. Bruce McArt, native of Anderson, will be associated with Dr. L. O. Rupe, Elkhart, after July 1. Doctor McArt is a graduate of Indiana University School of Medicine and served his residency at Indianapolis General Hospital.

Supplement to List of TV Films Available

The Committee on Medical Motion Pictures of the American Medical Association has announced the publication of a supplement to the list of health education motion pictures cleared for use on television. This supplement lists 38 motion pictures which have been cleared for television use since publication of the original list in 1951.

Copies may be obtained by writing to the Committee on Medical Motion Pictures, American Medical Association, 535 North Dearborn Street, Chicago 10.

Five Indianapolis doctors attended the May 4-8 national meeting of the American Psychiatric Association in Los Angeles. They were **Drs. Murray DeArmond, John H. Geist, Louis W. Nie, George S. Rader, and Philip B. Reed.** Doctor Reed also took part in meetings of the National Association of Psychiatric Hospitals preceding the APA and a meeting of the Electroshock Research Organization.

The Research Grants Committee of Eli Lilly and Company recently approved a grant to provide a fellowship in the department of chemistry at the University of Notre Dame.

The fellowship, which will become effective September 1, will be under the direction of Dr. G. F. Hennion, professor of chemistry at Notre Dame.

The Sixth Annual Microbiology Institute, sponsored by the Department of Biological Sciences and Division of Adult Education, will be held at Stanley Coulter Hall, Purdue University, June 22-27. Announcement of the course stated, "The fungi occupy a place of increasing importance in the economy, health, and daily living of the citizens of this country. The Institute was designed to bring to enrollees a familiarity with the important industrial molds and the latest information concerning culture and control." Fee for the course is \$50 which includes supplies. Full information may be obtained from: Industrial Microbiology Institute, Division of Adult Education, Purdue University, Lafayette, Indiana.

Dr. Michael F. Lynch, formerly of Elizabeth, New Jersey, has arrived in Crane Village for the general practice of medicine. The community has been without a doctor for several months. Doctor Lynch, a 1943 graduate of Hahnemann Medical College and Hospital, Philadelphia, served as a captain during World War II, practiced five years in Elizabeth, and has recently spent 18 months in Greenland during construction of an airstrip.

Challenger Inn, Sun Valley, Idaho, will be the site of the 61st Annual Meeting of **Idaho State Medical Association** on June 14, 15, 16 and 17.

The **First International Convention of X-ray Technicians** will be held in the Royal York Hotel, Toronto, Canada from June 28 through July 2. The session is sponsored jointly by the Canadian and American Societies of X-Ray Technicians. Membership is not necessary to participate in the programs. Additional details may be obtained from R. J. Vennie, R. T., 426 Oneida Street, Portage, Wisconsin.

Technical Bulletin Outlines G-G Criteria

The following bulletin was recently issued to all Indiana doctors by L. E. Burney, M.D., Commissioner, Indiana State Board of Health:

To All Physicians:

CRITERIA FOR THE ISSUING OF GAMMA GLOBULIN

The following criteria were established by a joint meeting of the Committee of Infantile Paralysis of the Indiana State Medical Association, members of the staff of the Indiana University School of Medicine and Hospitals and representatives of the Indiana State Health Officers Association, and members of the Indiana State Board of Health.

MEASLES

1. Gamma globulin may be given to all children from six months of age to four years of age.
2. It may be used for children who suffer from repeated illnesses.
3. It may be used for any child of any age known to have had tuberculosis.
4. It may be used for pregnant women who have not had measles and who have been exposed to three day measles.

INFECTIOUS HEPATITIS

Gamma globulin will be issued upon the following criteria:

1. Intimate contacts either familial, institutional, and/or attendants closely associated with care of patients.
2. Primary case must be reported by name; age, sex, address and date of onset.
3. If gamma globulin is furnished, the physician agrees to complete epidemiological forms as to the effectiveness of use on contacts.

It is regretted that it is necessary to ask physicians to complete a detailed requisition form. However, all gamma globulin has been taken over by the Office of Defense Mobilization. The allotment of gamma globulin to the State of Indiana for measles and infectious hepatitis for the year of 1953 is 13,600 cc. As you can see the amount of gamma globulin available to the State of Indiana is extremely limited and it is necessary that it be used only for measles and infectious hepatitis.

The gamma globulin for measles and infectious hepatitis is packaged in 2 cc. ampules and is not manufactured from large pooled sources of blood. Therefore, the gamma globulin for measles and infectious hepatitis is **NOT RECOMMENDED FOR PROPHYLAXIS AGAINST POLIO.**

Plan Physical Medicine, Rehabilitation Sessions

The 31st annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held on August 31, September 1, 2, 3 and 4, 1953 inclusive, at the Palmer House, Chicago.

Scientific and clinical sessions will be given on the days of August 31 and September 1, 2 and 3. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association.

Full information may be obtained by writing to the executive offices, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

The Seventh Annual Rocky Mountain Cancer Conference will be held in Denver on July 8 and 9. As in previous years there will be eight outstanding guest speakers, and on the first evening a banquet and entertainment for both the doctors and their wives. There is no registration fee for this conference, according to Harvey T. Sethman, executive secretary of Colorado State Medical Society, who adds that a considerable number of doctors are planning vacations to include several days in Colorado coinciding with the Cancer Conference.

Dr. Richard W. Artz, formerly of Flushing, New York, has established residence in Angola where he will be associated with Dr. Don Cameron on the surgical staff of Cameron Hospital. A graduate of Columbia University College of Physicians and Surgeons in 1943, Doctor Artz served three years as a medical officer with the United States Army in Europe. During the last seven years he has served several residencies in New York hospitals, currently completing a two-year residency in thoracic surgery.

Dr. Gerald G. Kring, who established his office for the practice of obstetrics and gynecology in LaPorte last July, has closed his office and reported April 21 to Fort Sam Houston, Texas, for military duty. Following his graduation from Northwestern University Medical School in 1948 Doctor Kring had three and one-half years hospital work in Chicago and Evanston before opening his office in LaPorte.

Six Indiana doctors attended the three-day 1953 meeting of the American Goiter Association in Chicago May 7-9. Those attending were **Drs. Goethe Link, Frank B. Ramsey, Glenn W. Irwin, Jr., L. H. Kornafel** and **Don C. Hines**, all of Indianapolis, and **Dr. J. O. Conklin**, Terre Haute.

"Careers for Maturing Workers" is the theme of the **University of Michigan Sixth Annual Conference on Aging** to be held in Ann Arbor July 8-10. The problems associated with earning in the later years and with methods for creating new opportunities for remunerative activity by aging people are particularly pressing, according to Wilma Donahue, Ph.D., chairman. Discussion sections will be lead by nationally known experts and exhibits and demonstrations of marketable skills will be a feature of the conference. For program details write to: Wilma Donahue, Chairman, Division of Gerontology, University of Michigan, 1510 Rackham Building, Ann Arbor, Michigan.

Supplement to A.M.A. Film Catalog Now Available

The A.M.A. Committee on Medical Motion Pictures has announced the publication of a supplement to the list of films available through the motion picture library. This supplement includes 12 motion pictures added to the library since publication of the December 1, 1952 catalog. Copies may be obtained by writing to the committee on Medical Motion Pictures, American Medical Association, 535 North Dearborn, Chicago 10, Illinois.

Announce PG Course In Gastroenterology

The National Gastroenterological Association announces that its Fifth Annual Course in Postgraduate Gastroenterology will be given at the Hotel Biltmore in Los Angeles, California on October 15, 16, 17, 1953.

The course will again be under the direction and co-chairmanship of Dr. Owen H. Wangensteen, Professor of Surgery of the University of Minnesota Medical School, who will serve as surgical co-ordinator and Dr. I. Snapper, Director of Medical Education, Cook County Hospital, Chicago, who will serve as medical co-ordinator.

Drs. Wangensteen and Snapper will be assisted by a distinguished faculty selected from the medical schools in and around Los Angeles whose presentations will cover all phases of gastrointestinal diseases and problems.

One complete session will be devoted to a Clinic at the College of Medical Evangelists at Loma Linda.

For further information and enrollment write to the National Gastroenterological Association, Department GSJ, 1819 Broadway, New York 23, N. Y.

A 10-day postgraduate course in hematologic diagnosis for graduate physicians will be given by Dr. Karl Singer at Michael Reese hospital, Chicago, from July 20 through August 1. Doctor Singer is director of the Department of Hematological Research of the Medical Research Institute. The course, on a fulltime basis, will give a review of present trends in hematology as well as actual instruction in reading of slides, normal and pathological specimens, peripheral blood and bone marrow. Further information and a copy of the curriculum may be obtained from the Department of Hematologic Research, Medical Research Institute, Michael Reese Hospital, 29th Street and Ellis Avenue, Chicago 16, Illinois.

The **Schering Award competition** for 1953 has begun in the nation's medical schools. Dr. M. William Amster, chairman, has announced

that three \$500 prizes will be awarded for papers of 5,000 words or less on the general topics of antihistaminic treatment of upper respiratory allergies and infections; therapy of the degenerative diseases and new concepts in the treatment of peptic ulcer. All students duly matriculated in medical schools in the United States and Canada are eligible. Deadline for entry forms is July 1 and the manuscript deadline is October 1. Numerous \$100 Deans' Awards will also be presented. Details may be obtained from Schering Corporation, 2 Broad Street, Bloomfield, New Jersey.

Dr. Merrill S. Davis, Marion physician and surgeon, was elected to the board of the James Whitcomb Riley Association at the recent annual meeting. He was renamed the association's vice-president.

Dr. E. S. Jones, Hammond, was elected second vice-president of the Industrial Medical Association at the annual convention in Los Angeles, April 20-24. Doctor Jones is chairman of the Committee on Industrial Health of the I.S.M.A.

Dr. D. S. Wiggins, New Castle, a senior member of I.S.M.A., who has been in retirement after 55 years of active practice, has been named full-time physician for the Indiana Village for Epileptics.

Appointment of **William N. Gregg** as manager of the Veterans Administration Center at Wadsworth, Kansas, is announced by VA.

Mr. Gregg is a native of Fairmount, Indiana. He served as a commissioned officer in both world wars, rising to the rank of lieutenant colonel.

In 1921, Mr. Gregg was employed in a clerical position at the National Soldiers' Home in Marion, Indiana. Five years later he became chief clerk at the National Soldiers' Home in Milwaukee, Wisconsin.

Dr. George H. Belshaw, who recently completed a term of service with the U. S. Air Force at Lackland Field hospital, San Antonio, is now associated with Dr. A. W. Cavins in the P and S Clinic, Terre Haute, where he will specialize in obstetrics and gynecology. Doctor Belshaw was graduated from Indiana University School of Medicine in 1946, served his residency at Methodist Hospital, Indianapolis, then practiced for two years in Fairmount.

The Department of Otolaryngology, University of Illinois College of Medicine, announces its **Annual Assembly in Otolaryngology**, divided into two sections: Basic Section, September 21 through 26, will be devoted to surgical anatomy and cadaver dissection of the head and neck, and histopathology of the ear, nose and throat, under the direction of Dr. M. F. Snitman; Clinical Section, September 28 through October 3, consisting of lectures and panel discussions, with group participation of otolaryngological problems and current trends in medical and surgical management.

Registration will be limited and application for attendance at one or both sections will be optional. For information write to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

Dr. Howard A. Rusk, director of the Institute of Physical Medicine and Rehabilitation of Bellevue Medical Center, New York University, College of Medicine, was the recipient on April 16 of the 1952 Mutual of Omaha Dr. C. C. Criss Award, consisting of a gold medal and a \$10,000 honorarium. The presentation took place in Atlantic City at annual dinner of the American College of Physicians of which Doctor Rusk has been a member for more than 20 years.

GP Officers Named; Road Show Announced

Dr. William R. Tindall, Shelbyville, was installed as president and presided at the

closing session of the Fifth Annual Scientific Session of the Indiana Academy of General Practice in the Antlers Hotel, Indianapolis, April 16.

Others who were named IAGP officers for 1953-54 are: Dr. Lawrence S. Bailey, Shelbyville, vice-president; Dr. O. T. Scamahorn, Pittsboro, president-elect; Dr. Russell J. Spivey, Indianapolis, immediate past president; Dr. Norman R. Booher, Indianapolis, secretary-treasurer.

Directors will serve one, two and three year terms and doctors named to that board include, Bernard E. Edwards, South Bend, Francis P. Jones, Indianapolis; W. D. Snively, Jr., Evansville; Floyd A. Boyer, Indianapolis; Frank H. Green, Rushville; James L. Lamney, Anderson; Frances T. Brown, Indianapolis; Neal E. Baxter, Bloomington; Ramon B. DuBois, Lafayette.

Delegates to the American Academy of General Practice will be Doctor Booher and Dr. Elton R. Clarke, Kokomo. Alternate delegates named were Dr. William R. Troutwine, Crown Point, and Dr. Lester D. Bibler, Indianapolis.

The Academy has announced that the June performance of their Medical Road Show will be held in Franklin Baptist church, Franklin, on June 10, afternoon and evening. First scientific presentation will be at 3 p.m. Speakers include Dr. E. Gray Dimond, professor of medicine, Kansas Medical School and Dr. Kurt Reissmann, associate professor of medicine, also at Kansas Medical School.

The program has been planned especially for the Seventh Councilor district but is an open meeting. Reservations should be made with Dr. Walter Portteus, Franklin, whose co-chairman for the meeting is Dr. Harry Murphy, Franklin.

Surgeons Rename Officers At First Annual Meeting

The Indiana Chapter, American College of Surgeons, renamed officers for a second term at their first annual meeting May 13 at Indiana University Medical Center. Dr. Carl H. McCaskey, Indianapolis, will again serve

as president; Dr. O. O. Alexander, Terre Haute, vice-president; and Dr. J. E. Pilcher, Indianapolis, secretary-treasurer.

Mail Fraud Results in Jailing of Phoney Doctor

Forged credentials on which he hoped to obtain an Indiana license to practice medicine

brought a three and one-half year prison term to Clone Sheldon Clay, 30, recent resident of South Bend, in Federal Court, Indianapolis, May 8. Clay, who claimed to be Dr. Clone S. Sheldon, Jr., licensed by Massachusetts, was stopped in his attempt to practice in Indiana through the combined efforts of the U. S. postal authorities and the State Board of Medical Registration and Examination.



A. M. A. RECOGNIZES AERO MEDICINE

The recognition by the A. M. A. of aero medicine as a branch of healing art climaxes a 5-year effort to obtain certification for specialists in Aviation Medicine. The American Board of Preventive Medicine will supervise aero medical practice, teaching and research. In addition to the A. M. A., the sponsoring organizations are, the American and Canadian Public Health associations, the Association of Schools of Public Health, the Southern Medical association and the Aero Medical association. The air force school's commandant, Brig. Gen. Otis O. Benson, Jr., has been chosen as the Board's first vice-chairman for aviation medicine.

A.M.A. WASHINGTON OFFICE NEWS

Draft Call Again Cut; 'Over-30' Inductions Halted in Priority 3. Physician draft calls for April-June period have been reduced again, this time from 1,200 to 966 and as a result Selective Service has halted physical examination and induction of all priority 3 physicians *over 30* (men born prior to August 31, 1922). The first cut came last February when President Eisenhower announced that military needs for physicians in the second quarter would be reduced from 1,800 to 1,200. Defense Department said its decision to cut the May call from 400 to 200 physicians stemmed in part from the fact that a number of reserve officers have been volunteering for longer periods of duty than the minimum two years. The June call is for 266 physicians.

Federal officials note that an estimated 2,700 young physicians in priorities 1, 2 and 3 will be completing internship or residency training this June. While there are no accurate figures on their division into priorities or how many may be deferred for physical reasons or continued study, this group may supply a large proportion of armed services needs for the rest of this year.

Six of 12,527 Physicians Denied Commissions on Loyalty Grounds. A compilation by the Army Surgeon General's office shows that of the 12,527 physicians coming into the three military services since start of the Korean war, only six have been denied commissions on grounds of questionable loyalty. The ratio for dentists is about the same, three out of 5,409.

Although 42 physicians and dentists have been inducted as privates during the period, 31 were subsequently commissioned or discharged for physical disability. Some of the 31, the Army said, simply waited too long to apply for a commission, and others were misinformed about the facts in their particular cases prior to induction. Several are known to have neglected to ask for a commission in the mistaken belief that they were not physically acceptable. Later, after induction, they qualified under the new lower standards for medical officers.

The tabulation:

Physicians

	Army	Navy	Air Force
Total number drafted as enlisted men-----	16	0	8
Commissioned after induction-----	12	0	6
Not commissioned because of loyalty factor-----	4	0	2

Dentists

Total number drafted as enlisted men-----	13	3	2
Commissioned after induction-----	9	2	2
Discharged for physical disability-----	2	0	0
Not commissioned because of loyalty factor-----	2	1	0

Defense Dept. Sets up Commission to Study Dependent Care. Secretary of Defense Wilson has appointed a Citizens Advisory Commission on the Medical Care of Dependent Military

Personnel and asked it to start immediately on a study of this problem. It will hold its first meeting Monday, April 27, and is under instructions to report its findings and recommendations to Mr. Wilson "at the earliest practicable date."

The Commission will study all aspects of the controversial question of military medical care for dependents, including type and extent of care to be provided, categories of dependents eligible, and extent of facilities to be furnished by the federal government for these purposes.

Chairman of the Commission is Harold G. Moulton, Ph.D., formerly president of Brookings Institution. Other Commission members are Thomas I. Parkinson, president of Equitable Life Insurance Co. of America; Lewis W. Jones, (Ph.D.), president of Rutgers University; Dr. George W. Bachman, senior staff member of Brookings assigned to health matters; and Mrs. Eugene Meyer, wife of the chairman of the Board of the Washington Post. Legislation for an EMIC program—federal payments for maternity and infant care of enlisted men's families—again is pending in Congress, but Defense Department is not expected to take a stand on these bills until the Commission has had a chance to report.

Secretary of Health, Medicine Proposed for Defense Dept. Unless Congress rejects a reorganization plan now before it, the Defense Department will create the position of Assistant Secretary for Health and Medical matters, to be filled by presidential nomination. **AMA had urged that such a post be set up, "in an effort to insure a more equitable utilization of medical manpower by the armed services."**

On April 30 President Eisenhower presented Reorganization Plan No. 6 to Congress. Among other changes in Defense Department, it proposes appointment of six Assistant Secretaries, but does not specify their duties. Subsequently Secretary Wilson said that one would be assigned to health and medical fields.

Korean Body Armor Lowering Mortality Rate. Use of body armor by U. S. troops in Korea is helping reduce mortality rate (now under 2% of all wounded) but is increasing the proportion of non-fatal extremity wounds (now around 70%), according to Dr. Melvin A. Casberg, Assistant to the Secretary of Defense for health and medical affairs. Reporting on his recent 25,000-mile tour of overseas medical installations, Dr. Casberg forecast a higher percentage of quadruple amputees as a result of the higher percentage of extremity wounds, suffered by men who would have died except for the body protection. This, in turn, he said, would require more medical care, particularly nursing care. Dr. Casberg also noted an increase in head injuries, which he said may call for a redesigning of combat helmets. Accompanying him on the trip was Dr. I. S. Ravdin, member of his Medical Advisory Council.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

April 25, 1953

The Council of the Indiana State Medical Association convened for its spring meeting at 6:30 p.m., Saturday, April 25, 1953, in the Columbia Club, Indianapolis, with Dr. Elton R. Clarke, chairman, presiding.

Roll call showed the following present:

Councilors:

First District-----Herman T. Combs, Evansville
Paul D. Crimm, Evansville,
alternate and president
Second District-----A. G. Blazey, Washington
Third District-----William H. Garner, New Albany
Fourth District-----Charles Overpeck, Greensburg
George S. Row, Osgood, alternate
Fifth District-----M. C. Topping, Terre Haute
V. Earle Wiseman, Greencastle,
alternate
Sixth District-----Not represented
Seventh District-----Roy A. Geider, Indianapolis
Eighth District-----T. R. Hayes, Muncie, alternate
Ninth District-----Wemple Dodds, Crawfordsville
H. E. Klepinger, Lafayette, alter-
nate
Tenth District-----J. Robert Doty, Gary
James P. Vye, Gary, alternate
Eleventh District-----Elton R. Clarke, Kokomo
R. W. Lavengood, Marion, alter-
nate
Twelfth District-----M. B. Catlett, Fort Wayne
Thirteenth District---Kenneth L. Olson, South Bend
G. O. Larson, LaPorte

Officers:

Paul D. Crimm, Evansville, president
W. Harry Howard, Hammond, president-elect
Roy V. Myers, Indianapolis, treasurer
Frank B. Ramsey, Indianapolis, editor of THE JOURNAL
A. W. Cavins, Terre Haute, Associate Editor of THE JOURNAL
W. L. Portteus, Franklin, chairman, Executive Committee
James W. Denny, Indianapolis, member, Executive Committee

Guests:

Wendell C. Stover, Boonville, A.M.A. delegate
Cleon A. Nafe, Indianapolis, A.M.A. delegate
Robert H. Rang, Washington, A.M.A. alternate
E. L. Fitzsimmons, Evansville, chairman, Committee on Convention Arrangements
Harold C. Ochsner and J. William Wright, Indianapolis, co-chairmen, Committee on Public Policy, and Legislation
Albert Stump, attorney
James A. Waggener, executive secretary
Robert J. Amick, field secretary
Bruce G. Nowlin, field secretary

By consent, the minutes of the midwinter meeting of the Council, held at Indianapolis on January

25, 1953, were approved as printed in the March, 1953, issue of THE JOURNAL.

Reports of Councilors

The councilors announced the dates and places of their spring district meetings and invited the officers of the association to attend.

Standing Reference Committees of the Council

The chairman stated that he felt that many times matters which come before the Council could be better handled if they were referred to a committee for study and procurement of additional information before being voted on and for that reason he had appointed the following standing reference committees in the Council for 1953:

Public Policy and Legislation:

A. G. Blazey, chairman
W. U. Kennedy
M. C. Topping

Insurance (including Blue Shield matters):

Kenneth L. Olson, chairman
M. B. Catlett
W. Harry Howard
E. R. Clarke
Albert Stump, attorney

Proposed Amendments to Constitution and By-Laws:

Roy A. Geider, chairman
Herman T. Combs
William H. Garner
Paul D. Crimm

Veterans' Affairs:

Herman T. Combs, chairman
T. R. Hayes

Rural Health, and various special health agencies, such as Red Cross, Tuberculosis Association, Cancer Control, Polio, Crippled Children, etc.:

Charles Overpeck, chairman
M. C. Topping
Wemple Dodds

Industrial Problems:

J. Robert Doty, chairman
Kenneth L. Olson

Nursing and Hospital Problems:

M. B. Catlett, chairman
Roy A. Geider
W. U. Kennedy

Educational Affairs, including Postgraduate Study and Preceptorships:

Wemple Dodds, chairman
J. Robert Doty
Charles Overpeck

Proposals for Remission of Dues:

William H. Garner, chairman
A. G. Blazey
T. R. Hayes

Reports of Officers

The president, president-elect, treasurer and editor of THE JOURNAL had no reports to make.

Dr. Nafe, A.M.A. delegate, stated the A.M.A. delegates had no further report on the March 14,

1953, meeting of the House of Delegates, held in Washington, D.C., than that which appeared in the April, 1953, issue of THE JOURNAL. The reorganization bill and Dr. Blazey's resolution condemning the action of the Indiana delegates to the A.M.A. (to be introduced at the interim session of the Indiana House of Delegates April 26, 1953,) were discussed by Drs. Nafe, Blazey, Garner, Howard and Crimm.

Unfinished Business

1. *Nominations for Editorial Board.* The Council made no further nominations at this time. Dr. Samuel Mercer, Fort Wayne (dermatology), was nominated at the midwinter Council meeting.

2. *Medical Education Foundation Fund.* Dr. James W. Denny, chairman, reported receipts to date of \$74,514.04, with Indiana University School of Medicine getting a total of \$37,462.97. Out of thirteen pledges of \$1,000 last year, two of them came from Indiana. The Indiana quota for 1953 is \$50,000.00.

**1953 Annual Session, French Lick,
Monday, Tuesday and Wednesday,
October 19, 20 and 21, 1953**

Dr. Fitzsimmons, chairman, Committee on Convention Arrangements, reported on the entertainment features and the executive secretary read the scientific program for the French Lick meeting.

Legislative Matters

1. *Workmen's Compensation Law.* Dr. Ochsner reported that the Workmen's Compensation Law was not changed in the last General Assembly.

2. *Resolution on Public Law 779*, adopted by the Council of the Indianapolis Medical Society, and brought to the Council's attention at the midwinter meeting, was referred to the House of Delegates by consent.

3. The following resolution, on Public Law 779, passed by the Lake County Medical Society, was called to the attention of the Council as a matter of information:

WHEREAS, United States Public Law 779, commonly known as the Doctor Draft Act, will expire June 30, 1953, and many changes in the present provisions are being considered at this time, prior to the enactment of a new law, and

WHEREAS, we believe the opinions of the medical profession should be helpful and instructive to those charged with the duty of framing the new law, and

WHEREAS, the deferment of any physician who has never served in the Armed Forces makes it necessary at an earlier date to recall a physician who has already served his country one or more times, and

WHEREAS, we believe the medical practice of any physician called to serve in the Armed Forces can be adequately cared for by other physicians, and therefore no individual physician is truly essential, and

WHEREAS, we believe physicians of ages above 51 years, and physicians with physical handicaps, who

are nevertheless able to conduct civilian medical practices, could and should serve in the Armed Forces in certain limited military assignments, thereby reducing the need for other younger and more physically fit doctors who would then be available for more active assignments in the Armed Forces.

NOW THEREFORE BE IT RESOLVED that the opinions expressed herein be given due consideration in the forthcoming deliberations between representatives of the Armed Forces, the Selective Service System and the medical profession, and whatever action is required, be taken to bring about the inclusion in the provision of the new law.

Approved by the Council of the Lake County Medical Society, January 25, 1953.

Adopted by the Lake County Medical Society in regular session, February 12, 1953.

New Business

1. *Remission of state dues.* On motion of Dr. Doty, duly seconded, the Council voted to remit the 1953 state dues of a member of the St. Joseph County Medical Society for hardship reasons, at the request of that society.

2. *Resignation of Dr. F. E. Keeling, Portland, Eighth District councilor.* On motion of Drs. Geider and Olson, the Council accepted the resignation of Dr. F. E. Keeling, councilor of the Eighth District, as he is in service and intends to remain in service until he retires.

3. *Matters referred to Council by Executive Committee:*

a. At this time Dr. Portteus, chairman of the Executive Committee, introduced Mr. Bruce Nowlin, field secretary of the state medical association for northern Indiana.

b. *1954 annual convention at Fort Wayne.* The Executive Committee referred this matter to the Council with the recommendation that the convention not be held in Fort Wayne due to the impractical arrangement and the excessive cost of renting the Allen County Coliseum for three days. Dr. Portteus' motion to this effect was seconded by Dr. Doty, and carried.

Place for 1954 convention. On motion of Drs. Combs and Hayes, the Council voted to hold the 1954 convention in Indianapolis.

c. *Resolution regarding insurance rates in partnerships* was approved by the Council and referred to the House of Delegates, on motion of Drs. Blazey and Geider. (See page 527, House of Delegates minutes, for copy of resolution.)

d. *Resolution to discontinue interim meetings of the House of Delegates* was approved for submission to the House of Delegates on motion of Drs. Olson and Doty. (See page 528, House of Delegates minutes.)

e. *Resolution on better enforcement of the medical laws of the State of Indiana* was adopted and

referred to the House of Delegates for appropriate action on motion of Drs. Topping and Geider. (See page 527, House of Delegates minutes).

4. *Summer meeting of Council.* By consent, the next meeting of the Council will be held on Sunday, July 19, 1953.

There being no further business, the meeting was adjourned.

HOUSE OF DELEGATES

Interim Session, April 26, 1953

The House of Delegates convened for its interim session in the Assembly Room, Claypool Hotel, Indianapolis, at 10:00 a.m., Sunday, April 26, 1953, with the president, Dr. Paul D. Crimm, Evansville, presiding.

On motion of Drs. M. B. Catlett and Robert H. Rang, attendance slips signed by the delegates, showing 87 delegates, 11 councilors, 5 past presidents, the president, and the president-elect present, were accepted in lieu of a roll call. In addition, the editor and one associate editor of *THE JOURNAL*, the chairman of the Executive Committee, a co-chairman of the Committee on Public Policy and Legislation, two alternate councilors, the attorney for the association, three guest physicians, four county society executive secretaries, the president and vice-president of the Indiana Student AMA, the executive secretary and field secretaries were in attendance.

Dr. Wendell C. Stover, chairman of the Reference Committee on Credentials, announced that a quorum was present, and the chairman declared the House open and ready for the transaction of business.

The Chairman: According to Chapter XVI Section 1, of the By-Laws, the By-Laws may be amended at any annual convention by a *majority vote of all delegates present at that convention*, after the amendment has laid on the table for one day.

The House of Delegates may amend any article of the Constitution by a *two-thirds vote of the delegates present at any annual convention*, provided that such amendment shall have been presented in open meeting at the previous annual convention and that it shall have been published twice during the year in *THE JOURNAL* of this association.

(On motion of Drs. P. T. Lamey and J. William Wright, reading of the minutes of the meetings of October 28 and 30, 1952, was dispensed with as these minutes were printed in the December, 1952, *JOURNAL*.)

Reference Committees

The Chairman: In accordance with Chapter X, Section 1, of the By-Laws, I have appointed the following reference committees, to serve during this interim session only. As I read the names, will

the members of these reference committees please stand?

1. Sections and Section Work:

Minor Miller, Evansville (Vanderburgh),
Chairman
R. R. Calvert, Lafayette (Tippecanoe)
R. P. Good, Kokomo (Howard)
D. D. Stiver, South Bend (St. Joseph)
L. D. Bibler, Indianapolis (Marion)

2. Rules and Order of Business:

Ray Elledge, Hammond (Lake), Chairman
N. A. Hibner, Monticello (White)
J. M. Kirtley, Crawfordsville (Montgomery)
Paul Casebeer, Clinton (Parke-Vermillion)
Robert Johnson, Rushville (Rush)

3. Medical Education and Hospitals:

Paul Tindall, Shelbyville (Shelby), Chairman
D. G. Mason, Angola (Steuben)
I. E. Huckleberry, Salem (Washington)
G. O. Larson, LaPorte (LaPorte)
J. W. Denny, Indianapolis (Marion)

4. Public Policy and Legislation:

Ralph Everly, Indianapolis (Marion), Chair-
man
Paul Merrell, Indianapolis (Marion)
E. L. Fitzsimmons, Evansville (Vanderburgh)
Jack Shields, Brownstown (Jackson)
Harry R. Stimson, Gary (Lake)

5. Publicity:

Harry P. Ross, Richmond (Wayne-Union),
(chairman)
G. A. Thomas, Lafayette (Tippecanoe)
J. William Wright, Indianapolis (Marion)
Ralph C. Eades, Valparaiso (Porter)
D. L. Lashley, Tell City (Perry)

6. Hygiene and Public Health:

O. T. Scamahorn, Pittsboro (Hendricks),
Chairman
J. L. Allen, Greenfield (Hancock)
R. O. Zink, Madison (Jefferson-Switzerland)
Dennis Megenhardt, Indianapolis (Marion)
Earl W. Mericle, Indianapolis (Marion)

7. Amendments to Constitution and By-Laws:

Joseph Ferrara, Franklin (Johnson), Chairman
Clarence G. Kern, Lebanon (Boone)
V. L. Turley, Fowler (Benton)
J. K. Jackson, Aurora (Dearborn-Ohio)
Winton Thomas, Warsaw (Kosciusko)

8. Reports of Officers:

Clay A. Ball, Muncie (Delaware-Blackford),
Chairman
J. M. Lockhart, Connersville (Fayette-Frank-
lin)
A. E. Stinson, Roctester (Fulton)
Max Long, Marion (Grant)
J. A. Graf, Bloomfield (Greene)

9. Committee on Credentials:

W. C. Stover, Boonville (Warrick)
Truman E. Caylor, Bluffton (Wells)
Albert Stouder, Kempton (Tipton)
Clarke McClure, Knox (Starke)
R. L. Veach, Bainbridge (Putnam)

10. Committee on Miscellaneous Business:

J. E. Dudding, Hope (Bartholomew-Brown),
Chairman
W. B. Challman, Mount Vernon (Posey)
J. R. Nash, Albion (Noble)

Donald W. Ferrara, Peru (Miami)
G. M. Nie, Huntington (Huntington)

11. Committee on Prepaid Medical Insurance:

W. Harry Howard, Hammond (Lake), Chairman
Frank Beardsley, Frankfort (Clinton)
Robert Rang, Washington (Davies-Martin)
J. M. Paris, New Albany (Floyd)
William C. Reed, Bloomington (Owen-Monroe)

Reports of Officers

Dr. Elton R. Clarke, chairman of the Council, presented the following matters:

1. **Resolution on Public Law 779, adopted by the Council of the Indianapolis Medical Society, and referred by the Council of the Indiana State Medical Association to the House of Delegates without recommendation:** (*Referred to Reference Committee on Public Policy and Legislation. Adopted with a few changes in wording.) (* —) Indicates action taken. For full details, see reference committee report.

WHEREAS, some questions have arisen regarding the constitutionality of Public Law 779, generally known as the "Doctors' Draft Act;" and

WHEREAS, the Council on Emergency Medical Service of the American Medical Association now is conferring with Defense Department officials, Selective Service officials and representatives of the U. S. Public Health Service regarding possible revision of the law which expires June 30, 1953; and

WHEREAS, these conferences present an excellent opportunity for study and review of the actual constitutionality of the law on two points: (1) Is legislation of this type, which imposes on one professional group a double liability for military service, class legislation and, as such, violates constitutional guarantees?; and (2) Is the Army in drafting doctors and using them as enlisted men violating the due process provision of the constitution?; and

WHEREAS, while it is fully realized that Public Law 779 was established with a view toward fairly obtaining physicians for the Armed Services after other methods of procurement had failed, it also must be realized that no legislation should be allowed to remain on the statute books which actually is unconstitutional inasmuch as it may be an entering wedge for future constitutional violations;

WHEREAS, upon the enactment of the law which would replace Public Law 779, should there exist any doubt as to its constitutionality, a case in point should be tested before a United States Court to determine whether or not it violates the constitutional rights of the individual;

THEREFORE, BE IT RESOLVED, that officials of the American Medical Association in their conferences with interested governmental officials make every possible effort looking toward the law's revision in such manner as to insure its constitutionality; and

BE IT FURTHER RESOLVED, that a copy of this resolution be handed to the Executive Committee and Council of the Indiana State Medical Association and that they in turn be requested to forward it to proper officials of the American Medical Association; and

BE IT FURTHER RESOLVED, that the Indiana State Medical Association send a copy of this resolution to all members of the state's congressional delegation.

2. **Resolution concerning use of fees paid by Indiana physicians for medical licensure, adopted by the Council at its April 25, 1953, meeting:** (*Referred to Reference Committee on Miscellaneous Business, and adopted.)

WHEREAS, annual fees are paid for renewal of licenses to practice medicine, and the purpose of the law requiring such renewals in the amount of \$5.00 was to bring about more adequate protection of the public against practitioners of the healing art who are not well enough trained and educated to obtain licenses; and the amount of money made available for enforcement of the medical practice laws has been more during the last five years than has been used for that purpose, resulting in the return of this excess to the general fund of the State in the amount each year of about \$10,000.00 while at the same time there are many unlicensed practitioners who practice without interference, because of not having enough investigators at work nor enough legal service available to obtain adequate enforcement of the medical laws,

THEREFORE, BE IT RESOLVED, that The Indiana State Medical Association recommends that the State authorities charged with the responsibility of enforcing medical laws study the following problems and take appropriate action in regard thereto:

1. Whether more investigators should be employed;
2. Whether more legal service should be provided by fuller use of funds obtained through fees for licenses and renewals thereof; and,
3. Whether other means may exist for expediting the final trials of pending cases, increasing the number of cases filed, and generally bringing about the termination of unlawful practices of the healing art.

AND, BE IT FURTHER RESOLVED, that this Association bring this resolution to the attention of the Governor, and all other state officials who have responsibilities in regard to the enforcement of medical laws, and extend to all such officials the assurance of the Indiana State Medical Association that it will continually cooperate in all legal efforts for better enforcement of the medical laws of the State of Indiana.

3. **Resolution regarding malpractice insurance rates in partnerships:** (*Referred to Reference Committee on Prepaid Medical Insurance, and approved as submitted.)

WHEREAS, information has been obtained by the Headquarters Office of the ISMA that certain medical malpractice insurance is being written on medical partnerships in which an extra charge is made to cover not only each of the members, but also the partnership on the basis that it is a separate entity the same as the individual members of the partnership and that this results in requiring a partnership consisting of two members to pay a premium of three times the rate for which an individual physician could obtain insurance instead of two times the rate, although the amount of risk

involved could be no greater than the combined risk on two individual physicians; and

WHEREAS, this method of charging premium rates results in discrimination against physician partnerships; and

WHEREAS, the AMA is making a study of medical malpractice insurance problems,

THEREFORE, BE IT RESOLVED, That the ISMA recommends and suggests that this method of ascertaining premium rates for insurance on medical partnerships be brought to the attention of the AMA House of Delegates; and that the Delegates from Indiana to the AMA House of Delegates be, and hereby are, directed to present this resolution to the next meeting of the House of Delegates of the AMA and urge that the AMA instruct its Committee studying malpractice insurance to take appropriate action to eliminate this element of discrimination in medical malpractice insurance policies.

4. **1954 annual convention at Fort Wayne.** Recommendation of the Executive Committee and the Council that the 1954 meeting not be held in Fort Wayne due to the high rental fee and impractical arrangement of the Allen County Coliseum, where the convention would have to be held, was approved on motion of Drs. Clarke and C. S. Black.

5. **Resolution to discontinue interim meetings of House of Delegates:** (*Referred to Reference Committee on amendments to Constitution and By-Laws. To be considered further at the French Lick meeting in October; county societies to be polled in the meantime.)

BE IT RESOLVED, that the Council of the Indiana State Medical Association recommend the discontinuance of the interim sessions of the House of Delegates to the Indiana State Medical Association for the following reasons:

1. We are all burdened with meetings, and generally all desire less meetings.
2. Cost of holding these meetings exceeds \$500.00.
3. There is a lack of time to give serious consideration to matters of business and many items of business cannot be transacted because there is not time to permit the matters to lay on the table for a day, as provided for in the Constitution and By-Laws.
4. Original intent of holding this meeting was to spread it out over the state. This has not been done.
5. If there is business of sufficient importance, a special meeting of the House of Delegates is provided for in the Constitution, and can always be called.

Therefore the Council recommends the adoption by this House of the above.

Dr. Cleon A. Nafe, delegate to the American Medical Association, spoke briefly on the special meeting of the House of Delegates which was held on March 14, 1953, in Washington, D. C.

Reports of Special Committees

1. *Dr. Lester D. Bibler*, chairman of the **Sub-committee on preceptorships**, presented the following report, which was referred to the Reference Committee on Medical Education and Hospitals, and accepted by the House of Delegates, with changes made by the reference committee: (See reference committee report for revisions.)

Following is an **interim report of the Preceptorship Committee** of the Indiana State Medical Association. The meeting of this committee was held February 1, 1953 in Indianapolis and the following members of committee were present: Doctors Kahler, Alvey, Van Nuys, Dudding and Bibler. Doctors J. O. Ritchey, Paul Fouts and E. W. Shrigley were invited guests. After considerable discussion the following recommendations were approved:

1. That a preceptorship type of program be offered through the Indiana School of Medicine to be available to late Juniors or during the Senior year.
2. That the preceptor shall be from the field of General Practice.
3. The selection of the preceptor shall be by the Dean's committee, with the assistance of the Indiana Academy of General Practice, and by a committee of the Indiana State Medical Association.
4. That no financial remuneration is to be considered for the preceptee or the preceptor at this time.
5. That a pilot plan be instituted to work out a satisfactory program.
6. That the length of instruction of such preceptorships should be not less than six weeks.
7. The students as well as the preceptors should be screened.
8. That the preceptorship should be an individual doctor rather than a group or clinic at this time.
9. The size or locality of the community should not be restricted.
10. That the State Association should help publicize this program.

The Chairman of this committee met with the Executive Committee of the Indiana State Medical Association and requested that a formal endorsement be forwarded to the Council of the Indiana School of Medicine endorsing this program. The request was approved by the Council of the I. S. M. A.

At the present time your committee is awaiting final approval by the Council of the Indiana University School of Medicine.

Lester D. Bibler, M.D., Chairman
 M. V. Kahler, M.D.
 Walter L. Portteus, M.D.
 Charles R. Alvey, M.D.
 Joseph E. Dudding, M.D.
 James W. Denny, M.D.
 John D. Van Nuys, M.D.

2. *Dr. Jack E. Shields*, chairman of the **Committee on Veterans Affairs and Rehabilitation**, presented a report, which was referred to the Reference Committee on Publicity. As authorized by the

House of Delegates, the complete report is not published here, but it is on file in the headquarters office. (See reference committee report for actions taken.)

Mr. President and members of the House of Delegates:

Your **Committee on Veterans Affairs and Rehabilitation** has met three times since the last meeting of this House, the last meeting having been held on Saturday, April 25, 1953 from 8:00 p.m. to midnight, with all but two members present.

Three principal subjects were discussed by this committee and our recommendations on these three subjects make up this report.

The first question discussed was the contract between the Indiana State Medical Association and the Veterans Administration for the "Home Care Program" of medical treatment of veterans in Indiana. After long discussion your committee, recommends that this contract be renewed in its present form.

The second point concerned the question of the efforts of chiropractors and other cults to gain recognition. The committee recommends that the House of Delegates recognize that the cultists have attempted to gain recognition through veterans organizations and the Veterans Administration. Further it should be recognized that the principal veterans' organizations have resisted these attempts to date and that this House gives hearty approval to this resistance by the veterans organizations and pledges the support of the Indiana State Medical Association in these efforts, wherein reasonably possible. **

Mr. President, I move the acceptance of this report on behalf of my committee.

Jack E. Shields, M.D., Chairman
W. B. Challman, M.D.
Herman T. Combs, M.D.
James L. Lamey, M.D.
Nelson B. Combs, M.D.
Norman R. Booher, M.D.
Dan E. Talbott, M.D.
L. S. Bailey, M.D.
John M. Palm, M.D.

New Business

At this time the chairman introduced Joe Ebbinghouse, president, and Jack Walters, vice-president, of the Indiana Student A.M.A.

It was taken by consent that the resolutions received prior to the meeting, copies of which were sent to each delegate, should not be read. These and other resolutions introduced from the floor of the House were referred to reference committees as follows:

Resolutions Referred to the Reference Committee on Medical Education and Hospitals

1. **Resolution from Committee on Physician-Hospital Relationships, concerning the magazine, "Trustee":** (*Adopted with changes in paragraph 5. See reference committee report).

WHEREAS, The American Hospital Association publishes a magazine entitled "Trustee",

(** One paragraph and eight recommendations deleted.)

AND WHEREAS, The editorial policies of the magazine "Trustee" is determined only by representatives of the American Hospital Association,

AND WHEREAS, this magazine "Trustee" is distributed to administrators and Board Members of Hospitals throughout the country,

AND WHEREAS, this magazine presents only the views and opinions of the American Hospital Association and the Hospital Administrators regarding problems of Hospitals and the Medical Staffs of Hospitals,

NOW THEREFORE BE IT RESOLVED, That the House of Delegates of the Indiana State Medical Association go on record as recommending that the American Medical Association investigate and implement a program that will present to the Administrators and Boards of Trustees of Hospitals the views of physicians regarding Physician-Hospital relationship and other information of mutual interest to physicians and Hospitals,

AND BE IT FURTHER RESOLVED, that a copy of this resolution be forwarded to the American Medical Association with the request that the resolution be presented to the House of Delegates of the American Medical Association for their consideration and approval.

Kenneth L. Olson, M.D., Chairman
Jess E. Burks, M.D.
Kenneth E. Comer, M.D.
C. C. Herzer, M.D.
J. M. Fleming, M.D.
T. M. Conley, M.D.
R. C. Beeler, M.D.
H. W. Conrad, M.D.

2. **Resolution introduced by Dr. Gordon Thomas, Lafayette, on use of foreign graduates in Indiana hospitals:** (*Rejected.)

Inasmuch as a number of hospitals in the state of Indiana are experiencing difficulty in filling their house staff positions, and

Inasmuch as there are a number of qualified foreign graduates who are interested in house staff positions in Indiana hospitals, and

Inasmuch as present regulations require an interne physician to be eligible for licensure in the state of Indiana and require a Resident physician to actually be licensed,

Be it therefore resolved that the Indiana State Medical Association call the above difficulties to the attention of the Indiana State Board of Medical Registration and Examination and request said Board to assist, in any way possible, in resolving these difficulties.

Resolution Referred to the Reference Committee on Public Policy and Legislation

1. **Dr. R. R. Calvert, Lafayette: Resolution on Public Law 779:** (*Rejected.)

RESOLVED: That the "Doctor Draft" Law (Public Law 779), be revised to provide that physicians, who have not reached their 51st birthday, be divided into two groups:

GROUP A—Those physicians never having military service; these men to be called according to age, the youngest being called first;

GROUP B—Those physicians who have had military service since September 15, 1940; these men to be called according to the length of military service, those with the least service being called first;

GROUP B shall not be called until Group A is completely exhausted.

*Resolutions Referred to Reference Committee
on Publicity*

1. Resolution objecting to A.M.A. Delegates Capitulation to Socialism (*Rejected.)

WHEREAS, the majority of our profession honor and sustain the principles of individual freedom and responsibility as outlined in the Constitution of the United States.

WHEREAS, the A.M.A. education program was supposed to uphold those principles in the interest of the public.

WHEREAS, other freedom loving individuals and organizations joined with the A.M.A. in such common purpose.

WHEREAS, the resolution of the A.M.A. House of Delegates to favor Presidential Reorganization Plan No. 1, is in direct opposition to previous objectives, and is a betrayal of the support given by the adherents of freedom.

BE IT RESOLVED, that the Delegates of the Indiana State Medical Association in Session this 26th day of April 1953, repudiate the dissolute stand taken by our national delegates, and hereby go on record as continuing to honor our word as opponents of all forms of socialism.

A. G. Blazey, M.D.,
Councillor, 2nd District
I. S. M. A.
March 20, 1953

2. Resolution for an Evaluation of Education Fund (*Rejected.)

WHEREAS, the members of the Indiana State Medical Association have for the past few years contributed considerable money in extra dues for the purpose of fighting the socialization of medicine in order to better protect our patients from inferior medical care, and,

WHEREAS, there was a balance of \$35,000 more than the previous year in the Association's treasury as of December 31, 1951, and,

WHEREAS, our Journal and Newsflashes have not contained sufficient information to properly warn our members of the continued drive of Congressional bills for further socialization of our nation, and,

WHEREAS, a resolution passed at the last House of Delegates session, requesting the I. S. M. A. to stimulate grass roots action on Section 3, of P.L. 590 has not been effected, and,

WHEREAS, we are now confronted with the Ives-Flanders Bill (S-1153), a direct takeoff from the Magnuson Report, which has similar socialistic features as were incorporated in a bill submitted by these same senators in 1949, and,

WHEREAS, there are many other bills now pending in Congress that have collectivist features that are not compatible with the best interests of our peoples, and about which they are poorly informed.

THEREFORE BE IT RESOLVED, that the House of Delegates of the I. S. M. A., in session this 26th day of April, 1953, requests a detailed audit of funds and reports of its uses in furtherance of our educational campaign against socialistic measures, to be made by the Committees on Public Policy, Legislation and Publicity with the assistance of the Treasurer of the I. S. M. A. Said report and audit to cover the year of 1952 and the first three months of 1953.

BE IT FURTHER RESOLVED, that such audit and detailed report be printed in the June issue of the Journal of the I. S. M. A. for 1953, so that the entire membership may be in a better position to appraise the value received for the amounts spent and retained in our educational campaign fund.

A. G. Blazey, M.D.,
Councillor, 2nd District
Indiana State Medical Association

*Resolutions Referred to Reference Committee
on Miscellaneous Business*

1. Resolution on Fee Schedule for Medical and Surgical Services for Indiana Welfare Department (*Approved.)

WHEREAS, There exists in various counties and localities of the State of Indiana varying fee-schedules and rates of payment for various medical and surgical services and procedures by the Welfare Departments and agencies,

AND WHEREAS, Such inequalities inevitably are used by the several Welfare Departments in jockeying down the price lists for individual counties,

AND WHEREAS, Some equitable price levels may in fact be reached, as witness the standard fee schedules adopted by the Veterans' Administration, and the Blind Aid Division of the Welfare organization.

NOW THEREFORE BE IT RESOLVED that a committee be named from the Indiana State Medical Association to confer with the Indiana Welfare Department at the state level to draw up a unified and standardized fee schedule for medical and surgical services.

This resolution was adopted at the March meeting (March 3, 1953) of the Howard County Medical Society for presentation to the Indiana State Medical Association.

Robert W. Phares, M.D., President
Richard P. Good, M.D.
Elton R. Clarke, M.D., Committee

2. Dr. Minor Miller, Evansville: presented the following resolution which had been approved by Vanderburgh County Medical Society:

Resolution on the Advertising of Medical Products (*Adopted.)

WHEREAS, The advertising of therapeutic agents in the official journals of the American Medical Association carries the implication of approval of the material by the Association, and

WHEREAS, every method of promotion of any product bearing the seal of a council of the A.M.A. is under the control of the council, and

WHEREAS, it is not difficult for advertising material to be so devised as to convey a somewhat

different total impact from what is actually justified, now therefore

BE IT RESOLVED that the Indiana State Medical Association declares that the appropriate agencies of the American Medical Association should exercise diligent care that advertising in the official journals and that promotion of "approved" products should conform both in spirit and in detail with the actual safety and the truly established indications of the product.

BE IT FURTHER RESOLVED, that delegates from the Indiana State Medical Association be instructed to present this resolution to the House of Delegates of the American Medical Association in New York this year.

Resolution Referred to the Reference Committee on Prepaid Medical Insurance

1. Resolution Referring to the Present Methods of Blue Cross-Blue Shield Insurance Promotion (*Not adopted.)

(Passed unanimously by the Vigo County Medical Society at its regular meeting, April 14, 1953.)

WHEREAS, Blue Cross and Blue Shield Plans have been the pioneers and are the largest carriers of voluntary Hospitalization and Medical Care insurance; and

WHEREAS, the vigorous promotion of Blue Cross and Blue Shield insurance in Vigo County has created the erroneous public impression that physicians own, operate and recommend Blue Cross, Blue Shield insurance, to the exclusion of all other Hospitalization and Medical Care insurance;

THEREFORE, BE IT RESOLVED, the Vigo County Medical Society, Indiana State Medical Association and all individual physicians in Indiana, continue to advocate, support and cooperate with voluntary Hospitalization and Medical Care insurance; and

BE IT FURTHER RESOLVED, that the Vigo County Medical Society, and the Indiana State Medical Association, as organizations, refrain from sponsoring or recommending any insurance company in a manner that creates, or can be used to create, the impression that all other, or any other insurance companies are excluded.

William C. Kunkler, M.D., Delegate
Hubert T. Goodman, M.D., Delegate

Afternoon Session

Following luncheon in the Chateau Room of the Claypool Hotel, the House reconvened at 1:50 p.m. in the Assembly Room.

The executive secretary announced that the House of Delegates will meet at 6:30 p.m., Sunday, October 18, 1953, at the French Lick Springs Hotel, and delegates should make their hotel reservations accordingly.

Reports of Reference Committees

MEDICAL EDUCATION AND HOSPITALS

Dr. Paul R. Tindall, chairman, presented the following report, which was adopted section by section and as a whole, as noted:

Your committee approves the resolution concerning the magazine publication "Trustee" and such changes as to make paragraph 5 read as follows:

NOW THEREFORE BE IT RESOLVED, That the House of Delegates of the Indiana State Medical Association go on record as recommending that the American Medical Association go on record as recommending the establishment of a liaison committee with the administrators and boards of trustees of hospitals, setting forth the views of physicians regarding physician-hospital relationships and other information of mutual interest to physicians and hospitals.

(Dr. Tindall's motion for adoption of this section duly seconded, and carried.)

The committee recommends the rejection of the resolution submitted by Doctor Thomas in regard to the use of foreign graduates in Indiana hospitals for the following reasons:

The State Board of Medical Registration and Examination has recently been able to secure approval by the Attorney General of a ruling which permits the use of foreign graduates in hospitals who have completed two years of postgraduate work in an American hospital in lieu of the repetition of the senior year in an approved U. S. medical school, and in certain circumstances certain foreign graduates may obtain licensure by endorsement from other states. The other proposed rulings were not approved by the Attorney General, as is provided by law.

(Dr. Tindall's motion for adoption of this section duly seconded, and carried.)

The report of the Preceptorship Committee was accepted with changes in items 1, 3, 6, and the final paragraph to make them to read as follows:

1. That a preceptorship type of program be offered through the Indiana School of Medicine, to be available during the senior year.
3. The selection of the preceptor shall be made by a committee composed of representatives of the Indiana University School of Medicine, the Indiana Academy of General Practice and the Indiana State Medical Association.
6. That the length of instruction of such preceptorship should be not less than four weeks.

The last paragraph was changed to read, "this request was approved by the Executive Committee of the Indiana State Medical Association."

(Adopted on motion of Drs. Tindall and G. O. Larson.)

Paul R. Tindall, M.D., Chairman
G. O. Larson, M.D.
James W. Denny, M.D.
D. G. Mason, M.D.
I. E. Huckleberry, M.D.

(On motion of Drs. Tindall, Clarke and Kenneth L. Olson, report was adopted as a whole.)

PUBLIC POLICY AND LEGISLATION

Dr. Paul Merrell, acting chairman, presented the following report, which was adopted section by section and as a whole, as noted:

The members of the Reference Committee on Public Policy and Legislation met at 11 a.m., April 26, 1953, and considered the following:

1. Resolution on Public Law 779, adopted by Council of the Indianapolis Medical Society, and referred to House of Delegates by the Council of the Indiana State Medical Association:

WHEREAS, some questions have arisen regarding the constitutionality of Public Law 779, generally known as the "Doctors' Draft Act;" and

WHEREAS, the Council on Emergency Medical Service of the American Medical Association now is conferring with Defense Department officials, Selective Service officials, and representatives of the U. S. Public Health Service regarding possible revision of the law which expires June 30, 1953; and

WHEREAS, these conferences present an excellent opportunity for study and review of the actual constitutionality of the law, we feel legislation of this type, which imposes on one professional group a double liability for military service is class legislation, and, as such, violates constitutional guarantees; and

WHEREAS, while it is fully realized that Public Law 779 was established with a view toward obtaining physicians for the Armed Services after other methods of procurement had failed, it also must be realized that no legislation should be allowed to remain on the statute books which actually is unconstitutional inasmuch as it may be an entering wedge for future constitutional violations;

WHEREAS, upon the enactment of the law which would replace Public Law 779, should there exist any doubt as to its constitutionality, a case in point should be tested before a United States Court to determine whether or not it violates the constitutional rights of the individual;

THEREFORE, BE IT RESOLVED that officials of the American Medical Association in their conferences with interested governmental officials demand the law's revision in such manner as to insure its constitutionality; and

BE IT FURTHER RESOLVED that a copy of this resolution be forwarded to the proper officials of the AMA; and

BE IT FURTHER RESOLVED that the Indiana State Medical Association send a copy of this resolution to all members of the state's congressional delegation.

After much discussion of the wordage and the points brought out, motion duly made and seconded, and resolution in this form passed unanimously by the reference committee. (Adopted by House on motion of Drs. Merrell and Shields.)

2. The second resolution studied by your reference committee follows:

RESOLVED: That the "Doctor Draft" Law (Public Law 779), be revised to provide that physicians,

who have not reached their 51st birthday, be divided into two groups:

GROUP A—those physicians never having military service; these men to be called according to age, the youngest being called first;

GROUP B—those physicians who have had military service since September 15, 1940; these men to be called according to the length of military service, those with the least service being called first.

GROUP B shall not be called until Group A is completely exhausted.

After much discussion the fact was brought out that the above is included in the new proposed law, a copy of which is on each of your desks, and motion was duly made and seconded that the above resolution be rejected as superfluous at this time.

(Dr. Merrell's motion for rejection of this resolution by the House was seconded by Dr. Stimson, and carried.)

Ralph Everly, M.D., Chairman
Paul Merrell, M.D.,
Acting Chairman
E. L. Fitzsimmons, M. D.
Jack Shields, M.D.
Harry R. Stimson, M.D.

(Dr. Merrell's motion for adoption of the report in its entirety, was duly seconded and carried.)

PUBLICITY

Dr. Harry P. Ross, chairman, presented the following report, which was adopted section by section and as a whole, as noted:

Your Reference Committee on Publicity was given three assignments:

1. **Report of the Committee on Veterans Affairs and Rehabilitation.** We have studied this report and with your permission we wish to quote from the report:

"Three principal subjects were discussed by this committee and our recommendations on these three subjects make up this report."

"The first subject discussed was the contract between the Indiana State Medical Association and the Veterans Administration for the 'Home Care Program' of medical treatment of veterans in Indiana. After long discussion, your committee recommends that this contract be renewed in its present form."

It was moved by Dr. Wright, seconded by Dr. Lashley, members of this reference committee, that this section of the report be accepted as written. (Accepted on motion of Dr. Ross, duly seconded.)

"The second subject concerned the question of the efforts of chiropractors and other cults to gain recognition. The standing committee recommends that the House of Delegates recognize that the cultists have attempted to gain recognition through veterans' organizations and through the Veterans Administration. Further, it should be recognized that the principal veterans' organizations have resisted these attempts to date and that this House gives approval to this resistance by the veterans'

organizations and pledges the support of the Indiana State Medical Association in these efforts wherein reasonably possible."

On motion of Drs. Lashley and Eades, the reference committee unanimously accepted this part of the report. (Accepted by the House on motion of Drs. Ross and Black.)

In regard to the other matters discussed in the Veterans Committee report, we move that the standing committee continue its efforts and report further to this House of Delegates at the regular session in October. (Seconded by Drs. Bibler and Nafe, and carried.) ***

2. Resolution objecting to AMA delegates' capitulation to socialism. This reference committee recommends to the House of Delegates that this resolution do NOT pass as now worded. This reference committee believes that our delegates to the AMA represented us to the best of their ability and to the best interests of the medical care of the public, and to the best interests of the medical profession in general. We commend their action.

(Dr. Ross' motion for acceptance of this section of the report was seconded by Dr. M. E. Glock. Discussion by Drs. John Paris, J. L. Doenges, Robert Rang, James Denny, J. William Wright, P. T. Lamey and J. M. Kirtley followed. Adopted on rising vote.)

3. Resolution for an evaluation of Education Fund. It was moved, seconded, and carried, that this reference committee recommend to the House of Delegates that this resolution do NOT pass as now worded. The reference committee has been informed that an audit and accounting is already in process and will be presented in June or July. (Adopted on motion of Drs. Ross and Gordon Thomas.)

Harry P. Ross, M.D., Chairman
G. A. Thomas, M.D.
J. William Wright, M.D.
Ralph C. Eades, M.D.
Donald L. Lashley, M.D.

(Dr. Ross' motion for adoption as a whole of the report of the Reference Committee on Publicity of the interim session of 1953 was duly seconded, and carried.)

THE CHAIRMAN announced that the above Reference Committee on Publicity would serve for the French Lick convention in October, at which time discussion of the matters pertaining to veterans' affairs could be continued. It was recommended that the committee work with the reference committee during the period intervening between now and the annual convention.

(*** Three paragraphs of reference committee's report deleted, as authorized by the House.)

AMENDMENTS TO CONSTITUTION AND BY-LAWS

Dr. Joseph Ferrara, chairman, presented the following report, which was adopted on motion of Drs. Ferrara and H. R. Stimson:

Re: Resolution to Discontinue Interim Meetings of the House of Delegates

Your committee recommends that consideration of this resolution be continued to the French Lick meeting and in the interim, the opinion of the component county societies be obtained due to the fact that the resolution would tend to eliminate participation of the representatives of the component societies and place more responsibility on the Executive Committee and Council. Further recommend that the Executive Secretary send copies of this resolution and the recommendations of this committee to each county society with a request for approval or disapproval, and the information obtained be made available to this committee for final action at French Lick.

Joseph Ferrara, M.D., Chairman
Clarence G. Kern, M.D.
V. L. Turley, M.D.
Winton Thomas, M.D.
J. K. Jackson, M.D.

COMMITTEE ON CREDENTIALS

Dr. W. C. Stover, chairman, presented the following report, which was adopted on motion of Drs. Stover and Challman:

Your reference Committee on Credentials wishes to report that 87 delegates and alternates, 11 councilors, 2 alternate councilors, 5 past presidents, 5 officers, 1 attorney, 4 executive secretaries, 2 field secretaries and 6 guests registered at the Interim Session of the House of Delegates.

W. C. Stover, M.D., Chairman
Truman E. Caylor, M.D.
A. E. Stouder, M.D.
Clark McClure, MD.
R. L. Veach, M.D.

MISCELLANEOUS BUSINESS

Dr. J. E. Dudding, chairman, presented the following report, which was adopted section by section and as a whole, as noted:

1—Resolution on Fee Schedule for Medical and Surgical Services for the Indiana State Welfare Department:

Your Committee on Miscellaneous Business after much discussion among the members and members of the Association as visitors to this committee meeting approve the resolution for the appointment

of a committee from Indiana State Medical Association to confer with Indiana State Welfare Department at the state level to conduct a study of the advisability for a unified and standardized fee schedule for medical and surgical services. (Adopted on motion of Drs. Dudding and Challman.)

2—A Resolution concerning registration fees and enforcement of the Medical Practice Act:

This resolution was approved as read on the House floor. (Dr. Dudding's motion for adoption duly seconded, and carried.)

3—Resolution approved by the Vanderburgh County Medical Society on the advertising of medical products:

This resolution was adopted as read on the House floor. (Adopted on Dr. Dudding's motion, duly seconded and carried.)

J. E. Dudding, M.D., Chairman
W. B. Challman, M.D.
J. R. Nash, M.D.
Donald W. Ferrara, M.D.
G. M. Nie, M.D.

(Dr. Dudding's motion for adoption as a whole of the report of the Reference Committee on Miscellaneous Business was seconded unanimously.)

PREPAID MEDICAL INSURANCE

Dr. W. Harry Howard, chairman, presented the following report, which was adopted section by section and as a whole, as noted:

The resolution regarding malpractice insurance was approved as submitted. (Dr. Howard's motion for adoption of this section of report seconded by several, and carried.)

The reference committee on Prepaid Medical Insurance heard a large number of doctors discuss the resolution from the Vigo County Medical Society. There was general agreement that the Blue Shield and Blue Cross have done an excellent job in providing adequate medical insurance coverage at a reasonable cost.

While the committee is willing to endorse a reiteration of the policy that medical societies should not sponsor Blue Shield and Blue Cross to the exclusion of other good insurance, it is unwilling to endorse a resolution which many feel could be construed to imply that such exclusive endorsement had been widespread.

The committee hopes that officials of Blue Cross and Blue Shield will be able to take steps to resolve their differences with the Vigo County Medical Society, and recommends that the resolu-

tion as presented be not adopted. (Adopted on motion of Drs. Howard and M. B. Catlett.)

W. Harry Howard, M.D., Chairman
Frank Beardsley, M.D.
Robert Rang, M.D.
J. M. Paris, M.D.
William C. Reed, M.D.

(Report adopted as a whole on motion of Drs. Howard and Catlett.)

No further business appearing, on motion of Dr. Richard P. Good, duly seconded, the House adjourned, to meet again at 6:30 p.m., Sunday, October 18, 1953, at French Lick, Indiana.

EXECUTIVE COMMITTEE

April 25, 1953

Roll call showed the following present: W. L. Portteus, M.D., chairman; James W. Denny, M.D.; Paul D. Crimm, M.D., W. H. Howard, M.D.; E. R. Clarke, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump, attorney; James A. Waggener, executive secretary; R. J. Amick and Bruce G. Nowlin, field secretaries.

Membership Report

Number of members April 25, 1953 3,504*
Number of members April 25, 1952 3,444
Gain over last year 60
Number of members December 31, 1952 . 3,781

* Includes 122 in military service (gratis)

72—\$10.00 members (residents and interns)

255—senior members

65—members, dues remitted by Council

Number who have paid AMA dues: 1952 . 3,558;
1953 . 2,936

Statements of receipts and expenditures and report on the budget for March for the Association and *THE JOURNAL* were approved.

Headquarters Office

The Executive Committee recommended to the field secretaries that they more or less conduct a survey of the county medical societies to determine their relationships with their local welfare departments and as to whether or not advisory committees to the Welfare Department are in existence in their counties.

**1953 Annual Convention, French Lick,
October 19, 20 and 21, 1953:**

Technical exhibit:

a. Floor plan o. k.'d by consent.

b. Contract with Twiet's Display Company for exhibit booths was o. k.'d by consent with the understanding that the executive secretary and Mr. Stump are to include some additional agreements in the contract covering the supplies for the scientific exhibits.

c. The proposed plan for promoting traffic among the technical exhibits was approved. Each physician will be given a card when he registers on which the exhibitors will make notations that the doctor has visited their booths. On the last day of the convention a drawing will be held and three cards will be drawn. The Association will pay the three winners' hotel room and board bills, for not to exceed four full days.

It was suggested that the exhibitors be instructed to stamp cards only when presented by physicians themselves and not by their wives or members of their families.

Scientific exhibit:

a. Upon motion of Drs. Denny and Dr. Howard the committee approved its position of 1952 in which the association is to pay for the covering of tables and supplying of a flood light, if required, for each scientific exhibit.

Typewriters. Upon motion of Drs. Howard and Crimm the executive secretary was instructed to purchase three typewriters for convention use.

Badges. By consent the committee authorized the use of the same type badge as was used for the 1952 meeting.

Labor charges. The Secretary reported on his conversation and tentative agreement with the French Lick Springs Hotel management regarding labor and charges for the 1953 meeting. The same was approved by consent.

Gratuities. The secretary reported on the request of the catering manager and the hotel management for permission to place an additional \$1.00 per day per person on the room charge in lieu of gratuities in the dining room, stating that the management assures the Association that service would be better and the help would be happier with this arrangement. Approval was given this arrangement upon motion of Drs. Clarke and Crimm, with instructions that the management is to be requested to have signs on all tables explaining the fact that gratuities have been arranged for.

Organization Matters

Hospital survey. The secretary reported on the hospital survey program being conducted by Mr. J. B. H. Martin, former administrator of the I. U. Hospitals through the State Board of Health, with the assistance of a grant from the Kellogg Foundation.

Request of the Indiana Heart Foundation, Inc., for permission to use the name of the Indiana State Medical Association on a program kit on weight control was approved by consent.

Letter from the president of the Indiana Association of Licensed Nursing Homes, was read, in which he requested the appointment of a liaison committee from the state medical association to work with the Indiana Association of Nursing Homes in establishing medical standards. This request was approved by consent, providing the Association of Licensed Nursing Homes is willing to include the Indiana State Nurses Association on the liaison committee.

Medical Defense

Correspondence and discussion with the representatives of the St. Paul Mercury Indemnity Company regarding the medical malpractice insurance program and rates was discussed and the attorney was instructed to draw up a resolution for presentation to the Council of the association. This was done upon motion of Drs. Howard and Crimm.

Future Meetings

By consent the executive secretary and the chairman of the Committee on School Health and Physical Education were authorized to attend the National School Health Conference in Chicago, September 30 through October 2, 1953.

New Business

Receipt was noted of a resolution from the Blair County Medical Society, Altoona, Pennsylvania, regarding medical internship.

The matter of the State of Indiana reducing the budget of the State Board of Medical Registration and Examination, which would prohibit the publishing of their annual roster of licensed practitioners in the state and which is felt essential by the Medical Board, was discussed. It was also brought out that many physicians are critical of the large sum of money annually turned back to the State of Indiana, many feeling that this money should better be spent for the purpose of employing additional investigators for the purpose of policing unlicensed practitioners in the state. Following discussion of this matter, the following resolution was drawn up for presentation to the Council, with the recommendation that the Council in turn

present it to the House of Delegates for consideration and approval: (See minutes of House of Delegates, page 527).

The matter of the interim meetings of the House of Delegates was discussed, with some members of the committee feeling that the interim session as now held is not worth the time or expense in view of the results accomplished. Following discussion of this matter the Executive Committee by consent adopted the following resolution and instructed that it be presented to the Council: (See minutes of House of Delegates, page 528).

The Journal

Report on advertising was approved by consent:

Total, first quarter 1952	\$6,228.14
Total, first quarter 1953	5,897.91
Total, April, 1952	\$2,184.02
Total, April, 1953	2,118.68

There being no further business, the committee adjourned to meet again at 11:00 a.m., Sunday, May 24, 1953.

SECOND COUNCILOR DISTRICT

A symposium on "Carcinoma of the Lung" was featured at the scientific session at the Second Councilor District meeting held in Bloomington Country Club May 14. Panel members were Drs. Wayne Carson, Warren S. Tucker, David Rosebaum, John W. Beeler, all of Indianapolis, and Dr. Naomi Dalton, Bloomington.

Sullivan was selected as the site for the 1954 annual meeting and officers named for the coming year were Dr. Joe E. Dukes, Dugger, president, and Dr. J. S. Brown, Carlisle, who was renamed secretary.

The evening speaker was Dr. Paul D. Crimm, Evansville, president of the Indiana State Medical Association, who outlined several situations which currently affect the medical profession and discussed possible solutions.

Approximately 50 doctors and their wives attended the dinner and evening meeting.

FOURTH COUNCILOR DISTRICT

Approximately 125 physicians and their wives assembled at the Harrison Country Club, Columbus, May 6 for their forty-ninth annual Fourth District meeting. The meeting was in charge of William Wissman, M.D., president of the Bar-

tholomew-Brown County Society, host for the meeting.

The annual golf shoot was the first order of the meeting when many old rivalries were renewed on the links beginning at 9 a.m. with Doctor Robert O. Zink of Madison retaining his unofficial championship.

At noon the members and their wives were entertained at a buffet luncheon, which was followed by the meeting of the House of Delegates of the district.

Tribute was paid to the late Thomas D. Carpenter, M.D., president of the district society, whose untimely death occurred recently while serving with the Army in California.

The House voted to continue the meetings of the officers and delegates of the societies in the district with the councilor prior to the meeting of the House of Delegates of the Indiana State Medical Association.

Officers elected were as follows: District President, Joseph Black, M.D., Seymour; Vice-president, George S. Row, M.D., Osgood; Secretary, C. A. Wiethoff, M.D., Seymour. The 1954 meeting will be held the first Wednesday in May at Seymour with the 1955 meeting going to Batesville.

J. E. Dudding, M.D., Hope, was elected Councilor for the District to succeed Charles Overpeck, M.D., of Greensburg.

Three papers were presented during the scientific session. "The Management of the Painful Shoulder in General Practice" was the title of the discussion given by Charles H. Herndon, M.D., assistant professor of orthopedics, University Hospitals, Cleveland, Ohio.

John W. Martin, Jr., M.D., instructor in medicine, University Hospitals, Cleveland, gave a paper on "Pitfalls in Cardiac Diagnosis and Treatment."

A colored film on "Thoracic Surgery" and a discussion of this subject was given by Wayne Carson, M.D., associate professor of surgery, Indiana University School of Medicine.

FIFTH COUNCILOR DISTRICT

Three Indianapolis doctors presented the scientific program at the spring meeting of the Fifth Councilor district in the Elks' Club, Brazil, on May 13.

Dr. James Bowman, Indiana State Board of Health, spoke on "Gamma Globulin in Poliomyelitis"; Dr. Frank Teague, orthopedic surgeon, dis-

cussed "Feet"; and Dr. Donald W. Brodie, member of the State Alcoholic Commission, chose the subject "Alcoholism" for his paper.

A business meeting and election of officers concluded the afternoon meeting. Dr. Stuart R. Combs, Terre Haute, was named president and Dr. Cleon M. Schauwecker, Greencastle, secretary. The 1954 meeting will be held on May 19 in Terre Haute.

A social hour preceded the buffet supper at 7 o'clock. Dr. Paul D. Crimm, Evansville, president of Indiana State Medical Association, spoke briefly concerning some of the problems which he feels are of major importance to the medical profession and was followed by the guest speaker, Bernie Crimmins, head football coach at Indiana University who talked on "What It Takes to Do the Job."

Approximately 90 doctors and guests attended the meeting for which Clay County Medical Society was host. Dr. Robert K. Webster, Brazil, presided.

SIXTH COUNCILOR DISTRICT

Members of the Sixth Councilor district and their wives gathered at the Country Club, Connersville, on Thursday, April 30, for their annual meeting. Nearly 100 were present for the noon luncheon.

Harry P. Ross, M.D., Richmond, district president, called the meeting to order at 11 a.m. and extended the welcome to those present.

W. U. Kennedy, M.D., New Castle, district Councilor, in making his report stated that during the year "Harmony in the district has been the order of the day". Doctor Kennedy also gave a report on his visits with members of Congress immediately prior to the district meeting and urged all members of the district to take an active interest in legislative matters, calling particular attention to the Flanders-Ives bill, and the fact that many in Congress felt the medical profession does not move with the change of events. He urged strong

support of the Blue Cross and Blue Shield Plans as medicine's answer to the problem of providing adequate medical care to all.

During the business session the following officers were elected: District President, Robert W. Kuhn, M.D., Wilkinson; vice-president, John E. Fisher, M.D., New Castle; secretary-treasurer, W. R. Tindall, M.D., Shelbyville. The 1954 meeting will be held at the Elks Club in Shelbyville, the date to be set later.

Harry P. Ross, M.D., Richmond, retiring president of the district medical society, was elected Alternate Councilor for the district.

During the luncheon, Paul D. Crimm, M.D., Evansville, President of the Indiana State Medical Association, spoke briefly on the changing times in medicine and its organization and urged an understanding of new programs designed to place medicine in its rightful position of leadership.

Mr. James A. Waggener, executive secretary, spoke briefly on the programs of some of the Committees of the Association and explained the proposed new organization, The Indiana Foundation for Health.

Three papers and a panel discussion featured the scientific session. Karl Klassen, M.D., associate professor of surgery, Ohio State Medical School, gave a paper on "Diagnosis and Treatment of Solitary Pulmonary Lesions".

"Differential Diagnosis of Diffuse Pulmonary Lesions" was the title of the paper presented by John Prior, M.D., professor of medicine, Ohio State Medical School.

Robert Browning, M.D., professor of medicine and director of Ohio Tuberculosis Hospital, Ohio State Medical School, chose as the subject of his paper, "Current Trends in the Treatment of Tuberculosis".

A panel discussion on "Bronchitis and Emphysema" closed the program.



LOCAL SOCIETY REPORTS

LaPorte County Medical Society held a meeting on April 16 in the Willard Sea Food restaurant in Michigan City with 34 members in attendance. The speaker for the evening was Richard L. Landau, M.D., assistant professor of medicine at the University of Illinois School of Medicine, who presented a paper on the "Male Climacteric". At a business meeting it was decided to employ a part-time lay secretary.

At the county society's March 19 meeting in Peacock Fountain Inn, Rolling Prairie, the 27 members present discussed with their special guests, Dr. Alfred Ellison and Mr. Harry Davis, South Bend, the feasibility of employing a part-time secretary and deferred action until their April meeting.

"Present Day Psychiatry" was the topic of the paper given by Dr. Richard Jarvis before 21 members of the **Floyd County Medical Society** in the New Albany Country Club on April 10. The next meeting was scheduled for May 8.

At their first meeting of the year in New Harmony members of the **Posey County Medical Society** elected Dr. Harold E. Ropp, New Harmony, president; Dr. L. R. Thompson, New Harmony, vice-president; Dr. William B. Challman, Mount Vernon, secretary and delegate to the state convention, and Dr. Frank Oliphant, Mount Vernon, alternate delegate. Dues for the year were collected. The next meeting will be on call of the president.

Montgomery County Medical Society members heard Dr. Rollin H. Moser, Indianapolis, discuss "The Gastric Ulcer Problem" at their meeting held April 16 in Culver Union hospital, Crawfordsville. Doctor Moser's presentation was reported to be interesting and lively. He used lantern slides to illustrate cases discussed. Twenty-one members attended the meeting and dinner which followed. The next society meeting will be on May 21 with dinner at 7 p.m. and the meeting scheduled for 8 o'clock in the Culver Union hospital.

Members of **St. Joseph County Medical Society** met in Healthwin Hospital April 22, South Bend, to hear discussion of new concepts in cardiac surgery by four Chicago physicians and surgeons. Members of the panel were Dr. Jerome R. Head, Dr. Edward Avery, Dr. Theodore R. Hudson and Dr. John A. Graham. They reported their experiences in heart surgery, illustrating cases and new surgical procedures with movies. The annual election of officers was scheduled for May 12 with the meeting to be held in the Northern Indiana Children's Hospital.

Seventeen **Gibson County Medical Society** members met on April 13 in the Emerson Hotel, Princeton, for a dinner meeting. Dr. Emmett B. Lamb, Indianapolis, presented a paper on "Industrial Health" and his brother, Dr. Russell W. Lamb, Indianapolis, spoke on "Varicose Veins" which he illustrated with a film.

Dr. Paul E. Humphrey, Terre Haute, was the guest speaker at an April 15 dinner meeting of the **Parke-Vermillion County Medical Society** which was held in the Vermillion County Hospital, Clinton. Doctor Humphrey's paper was on "Diagnosis of Genito-Urinary Tumors." Fifteen members were present.

Members of the **Green County Medical Society** heard Dr. J. William Wright, Jr., Indianapolis, speak on "Hearing Defects in the Child" at their monthly meeting April 16. Fifteen members attended the dinner and program which were held in Freeman Greene County Hospital, Linton.

Seventy members of **Elkhart County Medical Society** heard F. D. Johnston, M.D., associate professor of internal medicine at the University of Michigan Medical School, Ann Arbor, discuss "Electrocardiography in the Practice of Medicine" at a meeting May 7 in the Hotel Elk-

hart. At a business meeting following the dinner it was voted to give full cooperation to the TB committee in planning and carrying out the oncoming roundup for chest X-rays. A report was made by the delegate to the Interim Meeting of the House of Delegates at Indianapolis. It was announced that the June meeting would be a social affair including members' wives.

Dr. Stuart R. Combs was elected president of the **Terre Haute Academy of Medicine** at a dinner meeting May 1 in the Hotel Deming, Terre Haute. Doctor Combs had served as secretary-treasurer for several years. He will be succeeded by Dr. Robert Solomon. Other officers are: Dr. M. L. CaJacob, first vice-president, and Dr. Robert Lancet, second vice-president. Those named to the board of directors were Dr. Roy Pearce, Dr. Noel S. McBride, Dr. Robert Kabel, Dr. J. L. Stoeltz and Dr. Burton E. Scherb, all of Terre Haute, and Dr. Wilbert McIntosh, Riley.

Members of **Orange County Medical Society** met May 5 in the French Lick Springs Hotel for a 7 p.m. dinner meeting with nine in attendance. Plans were made for the Third District meeting which will be held on June

17 at the French Lick Springs Hotel instead of on June 3 as previously announced. A golf match has been scheduled for the morning program, the district business meeting will be held from 2 until 5:30 p.m., followed by dinner and entertainment at 6:30 o'clock. The next county society meeting was to be held on June 2.

Dr. Robert Vandivier, Indianapolis, was a guest of **Putnam County Medical Society** at a meeting May 8 in the Union building on the DePauw campus. Fifteen members were present for the dinner meeting. Doctor Vandivier led a roundtable discussion on various new treatments and procedures concluding the program with a question period.

"You Practice Psychiatry" was the subject discussed by Dr. Omar Kenyon, psychiatrist on the staffs of General and University Hospitals, Indianapolis, before the **Tippicanoe Medical Society** in Lincoln Lodge, Lafayette, on April 14. A general discussion by the 38 members and 3 guests followed. A general business meeting preceded Doctor Kenyon's talk.

WOMAN'S AUXILIARY
to the
Indiana State Medical Association

Installation of the 1953-54 officers of the Woman's Auxiliary to the Indiana State Medical Association marked the conclusion of the annual House of Delegates meeting held April 22-23 at Indiana University, Bloomington.

Members of the Woman's Auxiliary of the Owen-Monroe County Medical Society were hostesses to the convention. Mrs. Elfred Hardtke is president and Mrs. Dillon Geiger was convention chairman. She was

assisted by Mrs. Ambrose Estes, Mrs. Philip T. Holland, Mrs. I. Taylor Reiger, Mrs. Paul E. Smith, Mrs. E. Bryan Quarles, Mrs. H. D. Schell, Mrs. William J. Stangle, Mrs. Hardtke, Mrs. J. W. Sibbitt, Mrs. James Topoligus and Mrs. Robert E. Lyons.

High praise was accorded the Owen-Monroe County Auxiliary for the well-planned convention.

Mrs. Charles F. Voyles, Indianapolis, installed the following new officers: Mrs. W.

Burleigh Matthew, Indianapolis, president; Mrs. Harry Harvey, Fort Wayne, president-elect; Mrs. William R. Tindall, Shelbyville, first vice-president; Mrs. J. W. Mather, East Gary, second vice-president; Mrs. F. P. Williams, Huntingburg, third vice-president; Mrs. C. P. McLaughlin, Pendleton, fourth vice-president; Mrs. W. L. Portteus, Franklin, recording secretary; Mrs. Ted L. Grisell, Indianapolis, corresponding secretary; Mrs. John M. Sullivan, Terre Haute, treasurer.

President's Report to the House of Delegates

April 23, 1953

Membership in our organization is limited to so few women in each community that it should be viewed as a privilege—and to have served as President of the Women's Auxiliary to the Indiana State Medical Association especially during our twenty-fifth year, is an honor that will always be a cherished memory.

The annual joint meeting of the Executive Committee of the I.S.M.A. and the Auxiliary in May, for the purpose of outlining the 1952-53 year was marked with the usual splendid understanding and co-operation. Early planning made it possible for our Program Chairman to assemble material and have program kits ready for distribution for the counties to use in formulating their plans for the year. This kit was so well organized that it received national recognition.

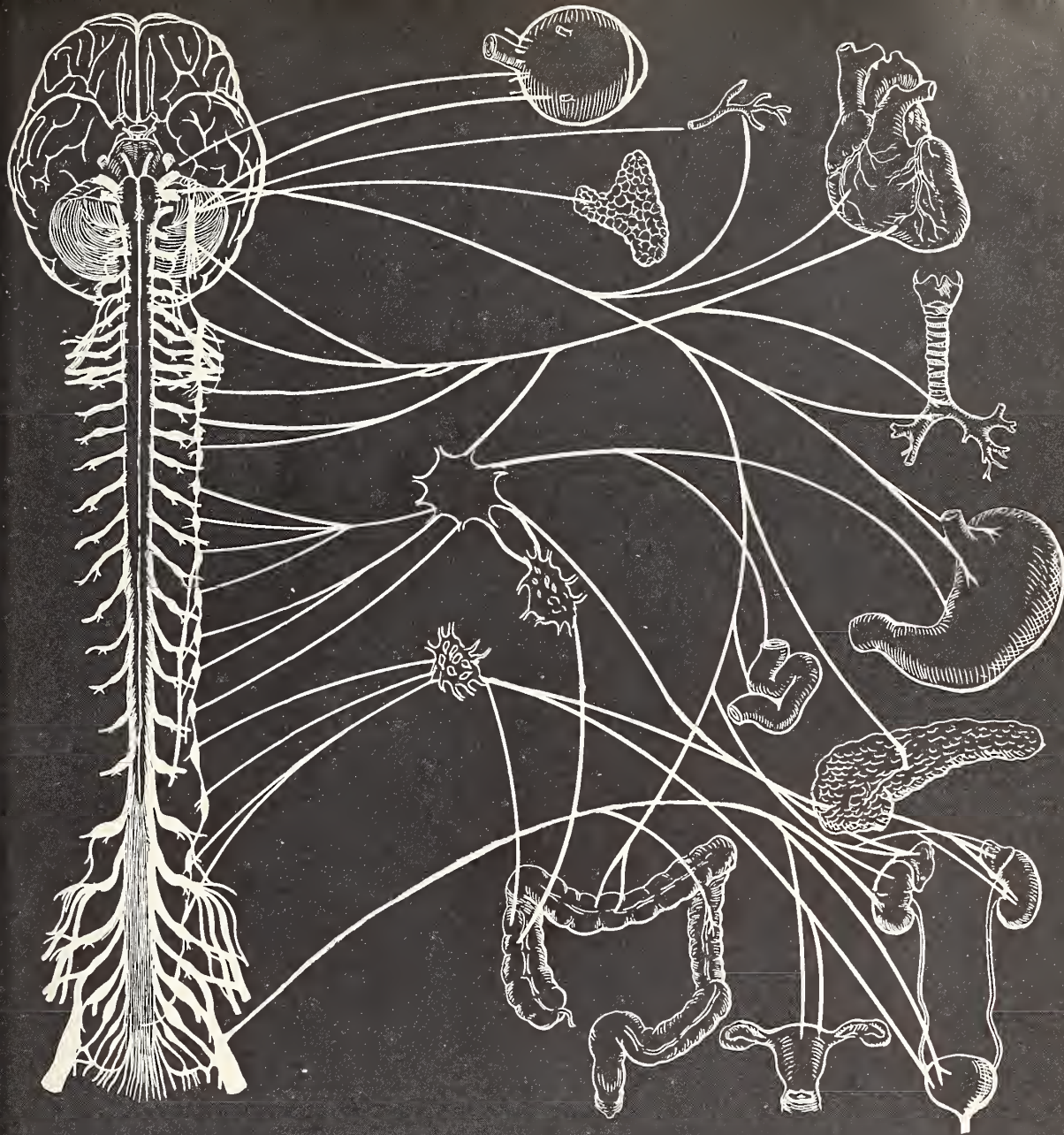
County meetings were many and varied—social, business and program, Civil Defense, Legislative, Membership, Public Relations, Panel Discussions, Educational, Nurse Recruitment, Rural and School Health and for lay groups.

Achievements for the year were legion—organization under the capable and enthusiastic leadership of our President-elect, with the able assistance of the Vice-Presidents, Councilors and County Auxiliaries, was outstanding. Six new Auxiliaries, representing 8 counties, were added to the roster and 3

additional counties merged with adjoining Auxiliaries, making a total of 11 new counties this year. The goal of 100% organization for Indiana, with the distinction of being the first state to achieve this, is in view, with just 6 of the 92 counties unorganized. Some of the contacts that paved the way for our organization team were made through the efforts of the Executive Secretary of the I.S.M.A. Military service, deaths and retirement from active practice depleted our ranks but we show an overall increase of 60 in membership. Our new Auxiliaries merit praise, for all dues and reports were returned on time and each was able to record some constructive contribution to our program.

Public Relations activities were extensive. Our members were represented in all phases of community activities and served on boards of many voluntary health agencies as well as other important local organizations. At the request of the Rural Health Committee of the I.S.M.A. the Auxiliary presented 4 Health Conferences. Booths at county fairs were staffed and Marion County Auxiliary had charge of the I.S.M.A. booth at the Indiana State Fair.

Nurse Recruitment was high on the agenda of Auxiliary activities. Teas and educational meetings and films were made available to prospective nursing students. Thirty-nine scholarships, gifts and loan funds were reported, with others in the planning. Grants varied from \$25 to \$400 and 61 student nurses were listed as having received Auxiliary assistance since this was adopted as an Auxiliary project. At the state level, the Auxiliary has awarded, for the past two years, a \$100 4-H Nursing Scholarship, administered by the Agricultural Extension Service of Purdue University. Approximately \$780.00 was available as loans from our Auxiliaries, \$3,600.00 as scholarships and more than \$315 as gifts of assistance in varying forms, to girls in training. Recruitment for Practical Nursing was added to the program for this past year as was the sponsorship of Future Nurses Clubs in the high schools. Twenty-one of these clubs were listed as organized under Auxiliary auspices and others received cooperation from our groups.



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Civil Defense educational programs were presented at the county level. Twenty Auxiliaries listed specific interest and activity, with a few, located in critical areas, participating in more intensive programs.

Legislation was in the foreground—and continues to be very important. Most Auxiliaries reported activity in the form of special meetings or briefs from the "Washington Letter", "Opinions From Here and There" and the "Newsflashes" presented at regular meetings. Public Legislative meetings were presented and with few exceptions, our members were active as individuals, in the elections. Our chairman distributed copies of "I.L.O. Spells Danger" to all counties and presented a resolution to our House of Delegates, going on record as favoring legislation to amend the constitution along the lines of the Bricker Resolution.

Today's Health subscriptions were increased over last year, but our record is still not that usually achieved by Indiana. Many Auxiliaries, with the assistance of their county medical societies and alone, presented gift subscriptions to schools, libraries, beauty and barber shops, Y.W. and Y.M.C.A.'s, social service clubs and agencies. Bulletin subscriptions were increased by 12. Four issues of the Hoosier Doctor's Wife, first published in 1947, were off the press. Our publication continues to be a good means of communication and excellent medium for exchange of ideas between Auxiliaries and members. We received space for publicity and reports in the Journal of the I.S.M.A. and in state newspapers.

Our A.M.E.F. Chairman spared no effort to achieve the objectives of "Every Auxiliary a Contributor." Results were good—39 counties contributed \$1424.11 and the State, through individual contributions and a cor-sage project at the House of Delegates added \$262 to this fund, for a total of \$1681.11. Vanderburgh County received a citation for its leading contribution of \$347.91.

County Auxiliaries used materials available through the A.M.A. agencies, especially transcribed radio series for presentation over local radio stations.

I travelled just short of 10,000 miles on Auxiliary business, attended 9 District meetings and visited with 11 County Auxiliaries. In addition, I attended 3 National Conferences, —June 1952 meeting of the W.A. to the A.M.A., Public Relations conference of the A.M.A., the annual conference of State Presidents and Presidents-elect; innumerable conferences and meetings for the Auxiliary planning, the General Assembly, House of Delegates and 4 Executive Committee meetings of the Auxiliary; spoke before the Southern District Nurses Association in Clark County on Future Nurses Clubs and the Business and Professional Women's Club of Terre Haute on Health Legislation; presented the first Auxiliary report to the House of Delegates of the I.S.M.A., was present at the July Health Conference in Lafayette, one day of the School and Community Health Workshop in Bloomington and the 4-H Health Conference in Lafayette in January; 5 Health Conferences presented by the Auxiliary, a Civil Defense meeting in Indianapolis, represented our immediate past president at a meeting of the Indiana Advisory Committee to the State Board of Health and served on the Advisory Committee of the Woman's Division of the Savings Bond Division of the U. S. Treasury Department. Our President-elect was official Auxiliary representative for a T-V interview, in connection with the Blue Cross-Blue Shield enrollment and again for a March Civil Defense meeting.

Official duties will terminate with the installation of officers, April 23, except for the privilege of presenting the report for Indiana at the annual meeting of the W.A. to the A.M.A. and serving on the Resolutions committee for that meeting.

Our heritage from the women who founded our Auxiliary a little more than 25 years ago, and those who have worked faithfully and selflessly to make possible our growth and development, is a great one. Our debt to them can be met only by assuming our individual responsibilities as physicians' wives and loyal Auxiliary members.

My thanks and deep appreciation go to each of you for making this such a happy and rich experience—the privilege of meeting



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104th CONVENTION—FRENCH LICK, OCTOBER 19, 20 and 21, 1953

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- Legal Counselor—Mr. Albert Stump, 1058 Consolidated Building, Indianapolis.

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For One Year (terms expire December 31, 1953): Karl Ruddell, M.D., Indianapolis, and Wendell C. Stover, Boonville. Alternates: Robert H. Rang, M.D., Washington, and Lall G. Montgomery, M.D., Muncie.

For Two Years (terms expire December 31, 1954): Cleon A. Nafe, M.D., Indianapolis, and E. S. Jones, M.D., Hammond. Alternates: Alfred Ellison, M.D., South Bend, and William C. Wright, Fort Wayne.

COUNCILORS

District	Councilor	Term Expires
1—	Herman T. Combs, Evansville.....	Dec. 31, 1953
2—	Arthur G. Blazey, Washington.....	Dec. 31, 1954
3—	William H. Garner, New Albany.....	Dec. 31, 1955
4—	Charles Overpeck, Greensburg.....	Dec. 31, 1953
5—	M. C. Topping, Terre Haute.....	Dec. 31, 1954
6—	W. U. Kennedy, New Castle.....	Dec. 31, 1955
7—	Roy A. Geider, Indianapolis.....	Dec. 31, 1953
8—	T. R. Hayes, Muncie.....
9—	Wemple Dodds, Crawfordsville.....	Dec. 31, 1955
10—	J. R. Doty, Gary.....	Dec. 31, 1953
11—	Elton R. Clarke (Chairman), Kokomo.....	Dec. 31, 1954
12—	M. B. Catlett, Fort Wayne.....	Dec. 31, 1955
13—	Kenneth L. Olson, South Bend.....	Dec. 31, 1953

1953-54 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	Charles P. Schneider, M.D., Evansville.....	C. Curtis Young, M.D., Evansville.....
2.	Joe E. Dukes, M.D., Dugger.....	J. S. Brown, M.D., Carlisle.....	Sullivan
3.	Joseph C. Dusard, M.D., Bedford.....	Eli Goodman, M.D., Charlestown.....	French Lick Springs Hotel, June 17, 1953
4.	Joseph M. Black, M.D., Seymour.....	Clifford A. Wiethoff, M.D., Seymour.....	Seymour, May 5, 1954
5.	Stuart R. Combs, M.D., Terre Haute.....	C. M. Schauwecker, M.D., Greencastle.....	Terre Haute, May 19, 1954
6.	Robert W. Kuhn, M.D., Wilkinson.....	W. R. Tindall, M.D.....	Shelbyville
7.	Ralph V. Everly, M.D., Indianapolis.....	T. V. Petronoff, M.D., Indianapolis.....
8.	Arvin Henderson, M.D., Ridgeville.....	Paul W. Sparks, M.D., Winchester.....
9.	Roland E. Miller, M.D., Lafayette.....	Hugh B. McAdams, M.D., Lafayette.....	Lebanon
10.	A. Lee Hickman, Hammond.....	Leo Cooper, Gary.....
11.	George W. Wagoner, M.D., Delphi.....	W. H. Hutto, M.D., Kokomo.....	Huntington, Sept. 16, 1953
12.	James M. Burk, M.D., Decatur.....	J. L. Eisaman, M.D., Bluffton.....
13.	John E. Luzzader, New Carlisle.....	O. E. Wilson, M.D., Elkhart.....	South Bend, November 18, 1953

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All articles must be typewritten, double-spaced, on one side of white paper, with margins of at least one inch.

Photographs should be printed on glossy paper. Negatives are not acceptable.

Only a limited number of illustrations can be used with each original article. If an excessive number are submitted for publication, the cost of extra illustrations must be borne by the author.

Contributors are responsible for all statements made in their articles. The editor and editorial board members may not be in agreement with various views expressed by authors, but it is desired to allow authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication only with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association. All communications regarding advertising and subscriptions should be sent to THE JOURNAL of the Indiana State Medical Association, 1017 Hume Mansur Building, Indianapolis 4, Indiana. Communications dealing with editorial matters should be sent to Frank B. Ramsey, M.D., Editor, 201 Hume Mansur Building, Indianapolis 4, Indiana.

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Opinions From Here and There

Prepared for your information by the Committee on Public Policy and
Legislation of the Indiana State Medical Association

Listed herewith are the actions taken by the A.M.A. Committee on Legislation and the Board of Trustees, which denotes the official position of the A.M.A. on various matters of legislation currently pending before the 83rd Congress. The reference to "Letter" appearing with the number of the bill denotes the number of the Washington Letter of the A.M.A. Washington office.

Members of the Armed Services or Their Dependents

S. 33
Letter #3
McCarran

To authorize medical care and hospitalization for dependents of Coast Guard in Naval hospitals when Public Health Service hospitalization is not available.

Active opposition. Adequate civilian medical care and facilities available.

**S. 932 Hunt &
Hendrickson**
Similar Bills—
H.R. 2724
Kilday
H.R. 3160
Cunningham

Would permit the commissioning of veterinarians as first rather than second Lieutenants, the practice followed from 1935-1949.

Active approval. Educational standards of veterinary medicine have been raised since 1949 and higher commissions for veterinarians are now justified. (Not previously reported.)

S 1531
Letter #15
Saltonstall

To extend and amend the Doctor Draft Act.

Approval on the basis of a one-year extension and suggesting several amendments. See testimony presented by the Association to the House Armed Services Committee April 24, 1953, which appeared in the Journal of the A.M.A., May 9, 1953, on page 166. Senate hearings under way.

H.R. 2452
Letter #7
Boggs

To furnish dispensary treatment in military hospitals for retired enlisted personnel.

Active opposition. Would merely enlarge the ever-growing number of persons eligible for federal medical care.

H.R. 2756
Letter #7
Seely-Brown

To authorize medical care and hospitalization for members of the Coast Guard and their dependents in *military* as well as Public Health Service Hospitals.

Active opposition. For the same reasons as indicated under S. 33 above, however, opposition is qualified insofar as care for dependents outside the continental United States is concerned.

H.R. 2955
Letter #8
Judd

Would amend doctor draft law and allow credit for time spent in armed services during World War 2 before as well as subsequent to Navy V-12 or ASTP programs.

(Now part of House passed bill)

Active approval. Would remove inequities in present law which do not recognize non-medical military service.

Medical Research and Establishment of Medical Foundations

S. 156
Letter #3
Langer

Would establish a National Epilepsy Institute in Public Health Service.

Active opposition because there is already existing authority for such a program under the supervision of the PHS.

S. 188 Ltr. #3
Neely
H.R. 583 Ltr. #3
Rooney
H.R. 2253
Letter #6
Elliott
H.R. 2693
Letter #7
Chiperfield

Would authorize the President to employ outstanding experts in an effort to discover means of curing and preventing cancer.

Active opposition. Great effort already is being made by government and private groups and proposed system would be ineffective.

H.R. 258
Letter #3
Elliott

Would authorize an additional annual appropriation of \$7,500,000 for research in connection with child life.

Active opposition. Children's Bureau already has authority to perform such research.

H.R. 2290
Letter #6
Morrison

Would establish a new institute for poliomyelitis in the Public Health Service.

Active opposition because there are already existing agencies for such a program under the supervision of the PHS.

Veterans and the Veterans Administration

S. 370 Ltr. #4
Murray
H.R. 28 Ltr. #2
Rogers
H.R. 261 Ltr. #3
Elliott
Similar—H.R. 2001
Ltr. #5—Rhodes

Would authorize 16,000 additional beds in veteran hospitals.

Active opposition in view of the facts contained in the report of the Special Committee on Federal Medical Services submitted in December 1952 indicating that VA facilities are adequate if abuses are corrected.

S. 609 Ltr. #5
Sparkman
H.R. 25 Ltr. #2
Rogers
H.R. 1573 Ltr. #4
Battle
S. 762 Ltr. #7
Martin
H.R. 33 Ltr. #2
Rogers

Would establish a presumption of service-connection for chronic and tropical diseases manifest within three years after separation from active service.

Active opposition. Would distort theory of compensation for disabilities that are in actuality not service-connected.

Would establish a rebuttable presumption of service-connection for active tuberculosis, psychosis and multiple sclerosis manifest within 3 years after separation from active service.

Active opposition for the same reason stated in S. 609 above.

H.R. 35 Ltr. #2
Rogers
H.R. 1543
Letter #4
Doyle

To authorize Administrator of Veterans Affairs to supply hospital care and medical treatment to veterans who are citizens of the U. S. visiting or residing abroad for service-connected disabilities.

Active opposition. The Association supports the principle of providing care for veterans with service-connected disabilities, but opposes these bills as drafted because they are too vague, and may possibly authorize

H.R. 45
Letter #2
Rogers

the construction of Veterans Administration hospitals overseas.

Would establish a rebuttable presumption of service-incurred or aggravated disability for malignant tumors becoming manifest within 2 years after separation from active service.

Active opposition. Bill sets up an arbitrary rule which the Association feels is not medically sound and for additional reasons listed under S. 609 above.

H.R. 46 Ltr. #2
Rogers
Similar bills:
H.R. 310 Ltr. #3
McDonough
H.R. 2097 Ltr. #6
Hagen

To establish a rebuttable presumption of service-connection for veterans developing tuberculosis other than pulmonary within 3 years after separation from active service.

Active opposition for reasons indicated for H.R. 45 and S. 609 above.

H.R. 54
Letter #2
Rogers

Would authorize the appointment of doctors of chiropractic in the Department of Medicine and Surgery of the Veterans Administration.

Active opposition.

H.R. 338
Letter #3
Rogers

To authorize Administrator of Veterans Affairs to furnish, if available, outpatient medical, dental and surgical treatment for non-service-connected disabilities to any veteran eligible for hospitalization who is entitled to compensation for a 100% disability or pension.

Active opposition in view of report of Special Committee on Federal Medical Services submitted in December 1952.

H.R. 1414
Letter #4
Rogers

To authorize the transfer of hospitals and other facilities between the Veterans Administration and the armed services.

Approval, would promote economy.

H.R. 2573
Letter #7
Rogers

To provide veterans of Spanish-American War, the Boxer Rebellion and Philippine Insurrection emergency hospital care as well as out-patient treatment as though they had a service-connected disability.

Active opposition. Would establish dangerous precedent subject to extension.

H.R. 2980
Letter #8
Rogers

To make available to all veterans entitled to eye care the services of qualified optometrists.

Opposition. (1) Would compel Chief Medical Director of VA to make available a particular type of service even though in his professional judgment it was not suitable in a particular case; (2) there can be no reliable evidence presented that veterans now are denied any eye care which the enactment of this bill would make available; (3) the training that an optometrist receives does not qualify him to give the veteran suffering from a visual disturbance "proper eye care;" the optometrist is not authorized by law to use medication or to employ surgery; and (4) the services of optometrists are now available in certain

cases in which an examination by a qualified ophthalmologist fails to disclose the existence of a cause of visual abnormality unrelated to lens power.

H.R. 3070
Letter #8
Frelinghuysen

To establish a presumption of service-connection for veterans developing amyotrophic lateral sclerosis becoming manifest within 2 years after separation from active service.

Active opposition for reasons outlined under S. 609 above.

Federal Aid to Education

S. 461
Letter #4
Humphrey

Would provide grants-in-aid and federal scholarships for post-graduate education in the field of public health.

Active opposition. Would jeopardize academic freedom of medical schools and for other reasons given re S. 337, 82nd Congress (Federal Aid to Medical Education).

H.R. 250
Letter #3
Elliott

Would authorize federal grants to states on a matching basis to finance health and safety instruction and physical education for school children.

Active opposition because this is a state and local problem and provides for unnecessary expenditure of federal funds.

H.R. 2718
Letter #7
Heller

To create a U. S. Medical and Dental Academy.

Active opposition. Facilities would be difficult to obtain, hospital service would be hard to execute in connection with the school and the manner of selection of entrants would probably be political.

H.R. 2838
Letter #8
Elliott

To establish a program of federal aid to students in higher education, the federal expenditures reaching eventually \$128 million annually.

Active opposition for reasons outlined under S. 461 above.

Tax Relief

H.R. 474
Letter #4
Keating

Would provide for a graduated scale of medical care deductions from gross income based on adjusted gross income. (Health expenses would include amounts paid for accident and health insurance).

Active approval in principle since it would afford individual relief in cases of extremely high medical expenses and would also be an incentive to buy voluntary health insurance.

H.R. 482
Letter #4
Keating

To provide for deductions of sums paid as premiums for health or medical insurance plans from federal income tax.

Approved in principle.

H.R. 2243
Letter #6
Dague

Would authorize deduction of medical and dental expenses from gross income for income tax purposes. Medical expenses would include amounts paid for accident or health insurance.

(Continued on Pages 684 and 686)

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HOUSE OF DELEGATES ROUNDUP REPORT REVEALS IMPORTANT ACTION

THE House of Delegates of the American Medical Association, in session at the Waldorf-Astoria Hotel during the 102nd Annual Meeting of the A.M.A. in New York City, took important policy actions on veterans' medical care, medical ethics, osteopathy, intern training and a wide variety of subjects ranging from medical education to public relations.

The House also named Dr. Walter B. Martin of Norfolk, Virginia, as president-elect of the American Medical Association for the coming year. Dr. Martin will become president at the June, 1954 meeting in San Francisco, succeeding Dr. Edward J. McCormick of Toledo, Ohio, who took office at a special inaugural session of the House of Delegates in the Hotel Commodore during the New York meeting.

The New York meeting was the largest ever held in the history of the American Medical Association, with the final figures on total attendance expected to reach or surpass 40,000, including nearly 18,000 physicians.

Giving unanimous approval to a recommendation from its Reference Committee on Insurance and Medical Service, submitted as a substitute for eight different resolutions concerning the treatment of non-service-connected disabilities by the Veterans Administration, the House adopted the policy that such treatment should be discontinued except in cases involving tuberculosis or psychiatric or neurological disorders.

In taking this action, the House reaffirmed and adopted the following recommendation originally presented at the Denver Meeting last December by the Special Committee on Federal Medical Services:

"Your Committee recommends with respect to the provision of medical care and hospitali-

zation benefits for veterans in Veterans Administration and other federal hospitals that new legislation be enacted limiting such care to the following two categories:

"(a) Veterans with peacetime or wartime service whose disabilities or diseases are service-incurred or aggravated, and

"(b) Within the limits of existing facilities to veterans with wartime service suffering from tuberculosis or psychiatric or neurological disorders of non-service connected origin, who are unable to defray the expenses of necessary hospitalization.

"Your Committee recommends that the provision of medical care and hospitalization in Veterans Administration hospitals for the remaining groups of veterans with non-serv-

ice connected disabilities be discontinued and that the responsibility for the care of such veterans revert to the individual and the community, where it rightfully belongs."

The reference committee report adopted by the House expressed complete accord with the present program of hospital and medical care for veterans with service-connected disabilities, and also included this statement:

Is Legislation Sound?

"It is the belief of your committee that the medical profession must concern itself, not with the numbers of 'chiselers' in Veterans Administration hospitals nor with the efficacy of the Veterans Administration in the administration of enabling legislation, but rather with the broad question of whether such legislation is sound, whether the federal government should continue to engage in a gigantic medical care program in competition with private medical institutions and whether the ever-increasing cost of such a program is a proper burden to impose on the taxpayers of the country. A consideration of this problem must of course be predicated upon a concern for the health of the entire population and not just a particular segment."

Eleven resolutions dealing with publicity regarding unethical conduct of physicians were brought before the House as a result of recent newspaper and magazine articles reporting statements attributed to an official spokesman of an allied medical organization. The House adopted a committee report which recommended no action on the eleven resolutions but which reaffirmed the supremacy of the A.M.A. code of ethics and urged that the Judicial Council study suggested revisions concerning methods of billing.

"The Principles of Medical Ethics as formulated, interpreted and applied by the American Medical Association must be considered the only fundamental and controlling application of ethics for the entire profession," the reference committee report said. "Any statement relating to ethical matters by other organizations within the general profession of medicine advances views of only a particular group and is without official sanction of the entire profession as represented by the American Medical Association."

Condemning generalized statements regarding the ethics of physicians, the report went on to say:

"Your reference committee believes that the harm done to the public and to the profession by the current articles which lower the confidence patients have in their doctors cannot be objectively evaluated. This highlights the fact that, when individuals or groups without official status in the American Medical Association utter or publish ill-considered statements, the result too often is that the confidence of the public in the medical profession is placed in jeopardy."

Deplores Ill-Advised Statements

"The reference committee believes that the members of the House of Delegates have demonstrated their devotion over the years to the principles of American democracy. This devotion includes the right of free speech. With this, the Committee agrees unqualifiedly."

"Broad generalizations, ill-advised and poorly prepared statements that often fail to convey the intended meaning are most unfortunate and are to be deplored. Destructive critical comments serve no useful purpose. Your committee has the utmost confidence that the great majority of our members are entirely capable of avoiding these pitfalls without additional advice from this committee."

The report also urged that the American Medical Association continue to inform its members and the public of its stand on matters pertaining to abuses and evils in the practice of medicine.

Most controversial issue brought before the House at the New York meeting proved to be the question of immediate or deferred action on the report of the Committee for the Study of Relations Between Osteopathy and Medicine. The House, after two hours of vigorous, spirited debate, adopted the majority report of the Reference Committee on Miscellaneous Business, thereby postponing action until the June, 1954, meeting and allowing further study by the delegates and the state associations.

The recommendations of the Committee for the Study of Relations Between Osteopathy and Medicine were as follows:

"1. That the House of Delegates declare

that so little of the original concept of osteopathy remains that it does not classify medicine as currently taught in schools of osteopathy as the teaching of 'cultist' healing.

"2. That the House of Delegates state that pursuant to the objectives and responsibilities of the American Medical Association which are to improve the health and medical care of the American people, it is the policy of the Association to encourage improvement in the undergraduate and postgraduate education of doctors of osteopathy.

"3. That the House of Delegates declare that the relationship of doctors of medicine to doctors of osteopathy is a matter for determination by the state medical associations of the several states and that the state associations be requested to accept this responsibility.

"4. That the Committee for the Study of Relations Between Osteopathy and Medicine or a similar committee be established as a continuing body."

Action Deferred

A minority report of the reference committee urged approval and adoption of those recommendations at the New York meeting. The majority report, which ultimately won out, included the following recommendations by the Board of Trustees:

"Because of the length of the report and the controversial nature of the subject, the Board feels that the House should have adequate time for its study and that the state associations should have opportunity to express their opinions.

"Therefore, it is recommended that the Committee be continued but that action on the report be deferred until the June, 1954, session. It is suggested that at that time the House be prepared to answer the following questions:

"1. Should modern osteopathy be classified as 'cultist' healing?

"2. Since the objectives of the American Medical Association include improvement in undergraduate and postgraduate education, should doctors of medicine teach in osteopathic schools?

"3. Should the relationship of doctors of medicine to doctors of osteopathy be a matter for determination by the several state associations?"

Five resolutions came before the House with regard to the Essentials of an Approved Internship, which were adopted at the December, 1952, meeting. The Reference Committee on Medical Education and Hospitals recommended a substitute resolution which was adopted by the House after considerable discussion. The action abolishes the rule whereby approval may be withdrawn from an internship program which for two consecutive years fails to obtain at least two-thirds of its slated complement of interns. The resolution also calls for further study of the Essentials by a committee appointed by the Speaker of the House, at least half of whom are doctors in private practice not connected with medical schools or affiliated hospitals.

Among the many other actions taken, the House reaffirmed its endorsement of the principles embodied in Senate Joint Resolution No. 1 concerning international treaties or agreements which interfere with domestic laws or rights, and it approved a resolution deploring a derogatory article about the American Medical Association which appeared recently in the Home Life Magazine. The latter resolution was referred to the Board of Trustees for implementation.

Distinguished Speakers Heard

Highlights of the opening day session of the House were addresses by Dr. Louis H. Bauer, who delivered his term-end report as retiring president; Dr. Edward J. McCormick, who spoke on that day as president-elect, and Mrs. Oveta Culp Hobby, United States Secretary of Health, Education and Welfare, and selection of the winner of the 1953 Distinguished Service Award.

Dr. Bauer, referring to charges of unethical practices among some doctors, declared that all members of the medical profession "should not be tarred with the same stick."

Dr. McCormick outlined a nine-point program for further improvement in the nation's medical care and expressed the hope that "their further development will solve many

of medicine's problems and eliminate much of the criticism to which we are subjected."

Mrs. Hobby told the delegates that the present administration in Washington is looking with confidence to the nation's physicians for leadership in meeting the challenge of modern medical care problems.

Honor Dr. Blalock

The 1953 Distinguished Service Award was voted to Dr. Alfred Blalock of Baltimore for his outstanding work in vascular surgery and his part in the development of the so-called "blue baby" operation. Dr. Blalock, chief surgeon at Johns Hopkins Hospital and professor of surgery at Johns Hopkins University School of Medicine, received the award during ceremonies preceding the presidential inauguration Thursday night, June 2.

In addition to the selection of Dr. Martin as president-elect, the House also elected Dr. Carl H. Gellenthien of Valmora, New Mexico, to the office of vice president. He succeeds Dr. Leo F. Schiff of Plattsburgh, New York.

Re-elected to office were:

Dr. George F. Lull, Chicago, secretary and general manager; Dr. J. J. Moore, Chicago, treasurer; Dr. James R. Reuling, Bayside, New York, speaker of the House of Delegates; Dr. E. Vincent Askey, Los Angeles, vice speaker of the House; Dr. Edwin S. Hamilton, Kankakee, Illinois, and Dr. Cunnar Gundersen, LaCrosse, Wisconsin, as member of the Board of Trustees.

The House elected Dr. Julian P. Price of Florence, South Carolina, to fill Dr. Martin's unexpired term on the Board of Trustees.



NFME SEEKS NATIONAL CHARTER

A bill (S-1748) to grant the National Fund for Medical Education a national charter has been introduced in the Senate by Sen. Robert A. Taft (R-Ohio). Through the proposed legislation, the National Fund would be on the same footing as the American Red Cross and a handful of other agencies who enjoy the prestige of a Congressional charter. Also it would help immeasurably in the fund's approach to industry and business for support of their program to help the nation's medical schools maintain financial independence and regain solvency.

INDIANA DELEGATES INTRODUCE 4 RESOLUTIONS AT A.M.A. MEETING



Pictured above are a group of Indiana delegates and alternates to the Annual Convention of the American Medical Association in New York. From left to right the spokesmen for Indiana State Medical Association are: Robert H. Rang, M.D., Washington, an alternate; Wendell C. Stover, M.D., Boonville, delegate; E. S. Jones, M.D., Hammond, and Cleon A. Nafe, M.D., Indianapolis, delegates.

INDIANA'S delegates to the American Medical Association's 102nd Annual Convention in New York played an important role in the activities and deliberations of the House. Shown above is a picture snapped of the Indiana delegation during one of the sessions of the House.

Cleon A. Nafe, M.D., Indianapolis, and E. S. Jones, M.D., Hammond, were appointed as tellers for the House.

W. C. Stover, M.D., Boonville, served as a member of the Reference Committee on Medical Military Affairs.

Announcing the committees appointed by the House following the 1952 Denver session, the name of Dr. E. S. Jones of Hammond, was included on the special committee roster for the purpose of studying the Matter of Prerequisites for Specialty Board Certification.

Also recognized by the House of Delegates was Norman R. Booher, M.D., Indianapolis, who was introduced before the House as representing the National Commander of the American Legion.

Indiana Resolutions

The Indiana delegation introduced the following resolutions, which had been adopted by the Indiana House of Delegates with instructions that they be carried on to the AMA.

Resolution regarding malpractice insurance rates, was referred to the Council on Medical Service for study and discussion in their present study of Malpractice Insurance Rates.

Resolution of Committee on Hospital-physician relations concerning the magazine "Trustee". The reference committee of the AMA recommended that no action be taken on this resolution as it was a matter for handling at the state and local levels.

Resolution concerning the advertising of medical products in the AMA Journal. This resolution was favorably considered by the Reference Committee and the House adopted its report which directed that proper officials of the AMA and the Councils take notice of the content of the resolution and that a thorough investigation be made of the matter.

Resolution concerning federal welfare requirements in Crippled Children's Program. This matter came to the attention of your Delegates during the New York meeting, when it was noted that a Federal requirement for approval of the State Plans included the following regulation, "*Sec. 200.9 Crippled Children's Program; Diagnostic Services.* State Plans for Crippled Children's Services shall provide that the diagnostic services under the Plan will be made available within the area served by each diagnostic center to any child (a) without charge, (b) without restriction or requirement as to the economic status of such child's family or relatives or their legal residence, and (c) without any requirement for the referral of such child by any individual or agency."

It was the feeling of your delegates that this provision was incompatible to the principles of the good practice of medicine, that the regulation as stated was socialistic and that the regulation as such should be changed to provide for a proper method of evaluation of the need on a basis similar to that used by the welfare department in its other services.

Accordingly a resolution on this matter was introduced, quoting the above section of the regulation, and the Reference Committee agreed with our thinking as did the House of Delegates which adopted the resolution as written.

It might be interesting to note that this resolution caused a great deal of activity on the part of the press covering the Convention, with stories appearing in the New York papers, where a crusade is underway to revise some of the welfare practices. The June 20 issue of Life magazine carries an editorial on the passage of this resolution which is a vicious attack upon the medical profession's action in adopting the resolution. But as is so many times the case, the reasons why, and the complete story are not told.

Many other important matters came before the House, some of which are carried in the Roundup story of the session which appears on page — of this Journal. For briefness and to avoid duplication your delegates call your attention to the Roundup story, and to the complete report of the proceedings of the New York Session which appears in the June 20 and 27 issues of the Journal of the A.M.A.

Large Registration

The New York meeting was the largest in the history of the A.M.A. with total registration reaching 38,500 of which 17,500 were physicians. Registration of Indiana physicians was supplied by the A.M.A.

Indiana doctors who registered were: John H. Alward, Kokomo; Eddie R. Apple, Salem; Theodore D. Arlook, Elkhart; W. E. Bayley, Lafayette; Edward R. Eaton, Indianapolis; Robert J. Frost, Michigan City; E. A. Garland, Evansville; C. C. Herzer, Evansville; Wendell C. Kelly, Anderson; Russell W. Lavengood, Marion; M. W. Manzie, Lyons; S. T. Miller, Elkhart; Harold T. Moore, Indianapolis; Carroll O'Rourke, Fort Wayne; Marion R. Shafer, Indianapolis; Paul W. Sparks, Winchester; W. J. Stangle, Bloomington; William O. Starks, Muncie; John V. Thompson, Indianapolis; Halden C. Woods, Markle; Irvin Zeiger, South Bend; David L. Adler, Columbus; Frank Forrey, Indianapolis; Greta M. Gibson, Indianapolis; Hugh S. Ramsey, Bloomington; Donald E. Spahr, Portland; Lester D. Bibler, Indianapolis; Burleigh W. Matthew, Indianapolis; Robert M. Butterfield, Muncie; Stanley M. Casey, Huntington; J. Vernal Cassady, South Bend; Patrick J. V. Corcoran, Evansville; B. M. Edlavitch, Fort Wayne; and Jack L. Eisaman, Bluffton.

Others attending during the five-day conven-

tion included C. E. Frankowski, Whiting; J. B. Eviston, Huntington; R. A. Fargher, LaPorte; Richard A. Ganser, Mishawaka; Frank M. Gastineau, Indianapolis; Ivan Gilbert, Terre Haute; Maurice E. Glock, Fort Wayne; Wayne R. Glock, Fort Wayne; Anson G. Hurley, Muncie; Robert D. Meiser, Huntington; Lall G. Montgomery, Muncie; Jean Pilot, Hammond; Clarence E. Reich, Evansville; Norman M. Silverman, Terre Haute; Merle E. Whitlock, Mishawaka; Daniel R. Benninghoff, Fort Wayne; Truman E. Caylor, Bluffton; R. L. Conklin, Elkhart; Paul D. Crimm, Evansville; John E. Dalton, Indianapolis; Cleon A. Nafe, Indianapolis; Thomas R. Owens, Muncie; and Stephen R. Phelps, South Bend.

Additional registrants were Bernard D. Ravdin, Evansville; H. H. Rodin, South Bend; Karl R. Ruddell, Indianapolis; R. L. Sensenich, South Bend; W. D. Snively, Jr., Evansville; S. L. Stern, Hammond; John M. Sullivan, Terre Haute; Henry G. Weiss, Evansville; Franklin A. Bryan, Fort Wayne; George D. Buckner, Fort Wayne; Don F. Cameron, Fort Wayne; Clyde

G. Culbertson, Indianapolis; Robert M. Dearmin, Indianapolis; William O. Denzer, Evansville; William T. Douglas, Montpelier; Mahlon G. Frasch, Lafayette; Max Ganz, Marion; Thomas A. Gill, Muncie; J. H. Gosman, Indianapolis; George F. Green, South Bend; Richard S. Griffith, Indianapolis; Emory D. Hamilton, Fort Wayne; Francis G. Henderson, Indianapolis; Robert E. Holsinger, Indianapolis; P. R. Irey, Plymouth; Robert W. VanBokkelen, Mooresville; Louis F. Sandock, South Bend; D. D. Johnston, Indianapolis; Harry E. Klepinger, Lafayette; Glen W. Lee, Richmond; B. N. Lingenman, Crawfordsville; Georgianna Lutz, Gary; Marvin L. McClain, Scottsburg; Robert J. Masters, Indianapolis; Carl G. Miller, Fort Wayne; Franklin B. Peck, Indianapolis; Richard M. Potter, Ridgeville; Alexander W. Rhind, Hammond; Raymond M. Rice, Indianapolis; John C. Slaughter, Jr., Evansville; John W. Smith, Indianapolis; Roy L. Smith, Indianapolis; D. K. Stinson, Rochester; James H. Stygall, Indianapolis; Charles D. Williams, Indianapolis; Fred M. Wilson, Terre Haute, and T. L. Wilson, Bloomington.



PRESIDENT EISENHOWER BACKS NF DRIVE

In a recent letter to S. Sloan Colt, president of the National Fund for Medical Education, commenting on the 1952 annual report of the fund, President Eisenhower stated that the financial crisis facing the nation's 79 medical schools "poses a dangerous threat to our national welfare." Mr. Eisenhower added that the "growing support from the medical profession and industry is indeed encouraging." In his letter to Mr. Colt, the President emphasized the vital importance of the National Fund and advised that "excessive reliance on government violates the essential principle of our free enterprise system."

LEGAL ADOPTIONS IN INDIANA AND THE STATUTES GOVERNING THEM

ALBERT STUMP*

BYRON EMSWILLER

Indianapolis

*A*LL LEGAL adoptions in Indiana are governed by statutes. The present effective statutes upon that subject were adopted by the Indiana Legislature in 1941, 1943 and 1949. They are incorporated in Burns' Annotated Indiana Statutes in Sections 3-115 to 3-125.

To analyze separately each act of the Legislature by section as reported in Burns' would make this article too long and might make it difficult to follow. So we have taken the whole body of law pertaining to adoptions and summarized its provisions in the shorter and, we believe, more understandable statement which constitutes the remainder of this article.

Any resident of Indiana over the age of 21 years may file a petition for the adoption of a child. The petition must be filed where the petitioner resides or in the county where the child may be found if there is a licensed child placing agency or governmental agency having custody of the child located in the county. The person seeking to adopt need not be married but if he or she is married, both spouses shall join in the petition unless one of the spouses is the natural parent of the child sought to be adopted and in that event, the consent of the natural parent must be filed with the petition.

The petition must be verified and filed in triplicate in the Circuit Court of the county or if the county has a Probate Court, in the Probate Court of the county. The petition shall state the name of the child, the sex, color and age, if known, and the place of birth of the child; the name to be given the child, the value and description of any property owned by the child, the name, age and place of residence of the adopting parent or parents; the name and place of residence, if known, of the

natural parents of the child, a statement concerning the present custody of the child and the period of time during which the child has lived in the home of the petitioner or petitioners.

After the petition has been filed with the clerk of the proper court, one copy is retained by the court, one copy is forwarded to the State Department of Public Welfare, and one to any qualified agency sponsoring the adoption. In most cases, the County Department of Public Welfare is the recipient of this copy. Thereafter within 60 days from the date of the reference of the petition to the agency, an investigation is made and a report of the agency is filed with the court. This report usually contains a recommendation by the agency, but the recommendation need not be followed by the court. The petition and report of the agency and all other matters connected with the proceeding is of a confidential nature, and the record remains in the hands of the clerk of the court and can only be inspected by order of the court.

In the hearing on the petition before the court, the court, in addition to hearing evidence on the matters set forth in the petition, requires a consent from the natural parents of the child or a consent from the person or agency having custody of the child. In event an illegitimate child is sought to be adopted and the mother of the child is under 16 years of age, her consent to the adoption must be witnessed by an authorized employee of the local agency.

What the Court Wants to Know

The court is interested in knowing the type of home the adopting parents live in, the earning capacity of the adopting parents,

* Attorney for the Indiana State Medical Association.

whether or not the adopting parents already have natural or adopted children, whether or not the adopting parents are cognizant of the fact that adopted children have practically all the rights of inheritance and other rights at law the same as natural children. Many courts also take into consideration the age of the adopting parents.

If the child sought to be adopted is of the age of 14 years, the child's consent to the adoption must be presented to the court. If the child has been abandoned for a period of 6 months, the consent of the natural parents is dispensed with. Where the child is illegitimate and paternity of the child has not been established, the consent of the natural mother is sufficient.

The court in determining an adoption proceeding is always interested in the welfare of the child and the child's best interests, and pays little heed to the desires or wants of the adopting parents. If the adoption is granted, an order is so made by the court and if so desired, a new birth certificate will be issued by the Board of Health indicating that the adopting parents are the parents of the child as though no adoption proceeding had ever been had.

The adopted child has all the rights of inheritance from the adopting parents as if he or she were a natural child of the parents and if the adopted child should die intestate, the natural parents of the child would have no rights of inheritance. The adoptive parents have the rights of inheriting from the child which the natural parents have where there is no adoption. If after the adoption, the adopting parents are divorced, the court may enforce orders for support of the child against the adopting parents as if they were the natural parents.

Any person over the age of 21 years may be adopted by any resident of this state in a manner similar to the methods set forth above but when this occurs only the consent of the person being adopted is necessary, and it is not necessary for the State Department of Public Welfare or any other agency to take part in the proceeding. In this situation a hearing may be set immediately after the filing of the petition.

Man Adopted at 55

Adoption take place for many reasons. One adoption which came to our attention occurred for a reason different than those generally thought of in connection with adoptions and the facts were these.

After the First World War a veteran returned home to his parents in Indiana. He brought with him to his home, a buddy whose parents were both dead. The buddy, like the man who came to dinner, extended his visit for years and remained in the household after his friend and his friend's father had passed away. He became the sole support of the mother of his deceased friend. He never married and spent all his time when not engaged in his employment caring for the wants and needs of his friend's mother. In view of the fact that the deceased friend's mother was entirely dependent upon him for her support and maintenance, he listed her as an exemption on his income tax return. At a later date the Tax Collector disallowed this deduction on the grounds that the dependent was not related in the proper degree to the taxpayer. To enable him to claim this exemption on his future tax returns the 80 year old lady adopted the 55 year old man.

In this situation we feel sure that the court gave as much consideration to the welfare of the woman as it did to the welfare and best interests of the middle-aged man being adopted.



More than 44,000,000 people are now enrolled in Blue Cross Plans, Richard M. Jones, Chicago, Director, Blue Cross Commission of the American Hospital Association, reports. This is an all-time high for the nonprofit hospitalization plans.

TRIANGLE OF INTERESTS IN ADOPTION SERVED BEST BY RECOGNIZED SOCIAL AGENCY

LOUISE GRIFFIN*

Indianapolis

ADOPTION of children now has the attention of the public as at no previous time in history. This method of providing children with substitute parents is by no means new. Since Biblical times adoptions have taken place. Increased public interest and general knowledge about what is good for children have, however, in recent years led to a more careful examination of just what adoption means to those most vitally involved and to constant re-examination of how the adoption process can be carried out to better serve the interests of all concerned.

Many years ago the focus in adoption was on helping childless couples find children to take as their own. They were praised for giving a "waif" a home and letting him inherit their estate. Sometimes the placement of the child seemed to be motivated largely by the desire of the officials to relieve the community of the cost of caring for a child who was a public charge. If the adoption did not work out well, there was little recognition that the development of problems, such as unacceptable behavior on the part of the child or action by the natural parent to reclaim the child, were frequently the result of hasty adoptive placements arranged without due consideration of the rights and needs of the natural parent or those of the particular child and without adequate evaluation of the ability of the adoptive couple to be good parents.

Through the years as more was learned about children and child-parent relationships, it became clear: (1) that in adoption we must deal with a triangle of interests—those of the child, the natural parents, and the adoptive parents—if the adoption is to have a fair chance for a happy ending; (2) that the main focus in adoption must be to provide the child

with security and a satisfactory parent-child relationship; and (3) that, to achieve this objective, the social casework services of a child-placing agency are needed.

In no sense does this change in focus mean that the interests and needs of adoptive parents are not fully considered. Indeed, it is to the advantage of the prospective adoptive parents as well as to the advantage of the child and his natural parents to have, prior to placement, a careful study of the child, of his natural parents' situation, and of the potentialities of the prospective parents. Such a study establishes that the child should rightly be separated from his natural parents, has become legally available for adoption, and is particularly suitable for the foster parents chosen for him. It is also to the advantage of all concerned to have these casework services continued until the adoption is consummated. The new relationship and responsibility of parenthood gladly assumed by the adoptive parents often fills them with anxiety and uncertainty. The integration of this new family unit is not something which blossoms automatically over night. Often both the adoptive parents and the child need the experienced help and guidance of a caseworker who has helped other foster parents and children through similar experiences. An older child may especially need the support of the caseworker to help him bridge the gap between the old and the new family.

Counselling Service Needed

Present day laws and professional practices which concern child placing and adoption have emerged from years of experience not only on the part of social agencies having responsibility under the law for child placing but also on the part of the professions of

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medicine and law. The medical profession has an important role in contributing to the decision regarding the physical and mental suitability of a child for adoption and also in determining the significant health factors of the adoptive parents which would affect their capacity to become satisfactory parents. The legal profession has responsibility for carrying out the legal process in adoption and for protecting the legal rights of those concerned.

The need for medical and legal services in adoption is generally understood and accepted. Less well understood by communities generally is the need for the services of the experienced and responsible social agency in placing children for adoption and in providing counselling service to the natural parents and to those who wish to become adoptive parents. Articles in widely read magazines regarding the operation of "grey and black markets" in adoption have done much in recent years to advise the public of the need for the services of qualified social agencies in making adoptive placements.

When we think of the triangle of interests—the child, the natural parents, and adoptive parents—whose needs and wants must be served in the adoptive process, it seems only logical that an experienced agency, impartial but not impersonal, advise and guide parents and prospective adoptive parents in making whatever plan is best for all concerned.

An authorized or licensed child-placing agency must be one to which natural and adoptive parents can and are willing to turn when they need help. Through practice and through interpretation to the public the agency must establish itself to that end. Too often we hear that some individual is placing children for adoption because he believes he can do a better job than the authorized or licensed agency. To a great extent this may be due to lack of knowledge about agency resources or to limited resources in the community and to lack of understanding of the legal provisions for placing children for adoption. There is also, of course, a limited realization of the serious responsibility involved in placing a child for adoption.

Fewer "Black Market" Babies

Interpretation of the problems involved and of the methods used is a major responsibility of all child-placing agencies as well as of professions and individuals who share responsibility for providing good services to children. One cannot be too critical of persons who make placements without authority if no attempt has been made to explain as widely and as carefully as possible those practices which will give the greatest protection to the child, his own and adoptive parents. Although the problem of "grey or black marketing in babies" is by no means solved, during recent years community after community has seen an increase in referrals to child-placing agencies after agency representatives have had a thorough discussion of adoption practices with representatives of key organizations, institutions, and groups in the community. The results of such conferences have been very rewarding.

A qualified child-placing agency should have a policy-making board of laymen and should be properly staffed and financed to offer counselling and financial assistance if necessary to parents seeking to place their children. Such an agency should offer a variety of types of foster care—institutions, boarding homes, and adoptive homes—and should have the time, qualified staff, and facilities for investigating and evaluating the needs of children referred to it and also the homes of persons applying for children to adopt. It should have available the services of a pediatrician, a psychologist, and a psychiatrist. It should also have the best legal advice available in order to avoid the tragedies that result when questions arise about the child's legal status after he has been placed for adoption. If there are any defects in the legal procedures and the consents required by law, the courts, when appealed to, are under great pressure to recognize the rights of the natural parents.

The existing agencies licensed or authorized to place children in Indiana are the 92 county departments of public welfare and 16 licensed child-placing agencies.

A great deal could be said with regard to the importance of protecting the child and his relationship to his natural parents. The parent

who is most often exploited for the purpose of obtaining a child for a childless couple is the unmarried mother, who is usually young and often without financial resources. She frequently has no one who can give her constructive help in meeting her very involved and difficult situation. She is frightened and confused about what plans can be made for her, and is also confronted with the need to make plans for the baby after his birth.

Protection Can Be Provided

It is extremely important that the unmarried mother have experienced and sympathetic service to help her arrive at a plan that she can feel is the best possible one for the child and for herself. She should never have to regret her decision in later life with the feeling that she acted hastily or that she was forced into making a plan because she had no funds or because there was no one to assist her who fully understood her situation. Because she is often uninformed of resources to meet her problems, she frequently looks to someone in the medical, legal, or religious profession for help. Members of these professions

are especially well situated to direct such a person to social agencies which can give the guidance and financial aid she may need in planning for herself and her child.

Indiana has continuing and serious problems in providing adequate protection to children, natural parents, and adoptive parents. Some of these problems are due to "human error" on the part of child-placing agencies; others are due to inadequate resources. Most of the problems in adoption cases, however, stem from unauthorized placements and evasions of the law which concerns child-placing or from placements made by own parents.

The licensing law, the adoption law, the juvenile court law, and the public welfare act can provide a large measure of protection to Indiana's children who are deprived of their own parents' care. These laws, however, can be fully effective only when social agencies and the professions of medicine, law, and religion work closely together and with all citizens in strengthening community services to children and in developing a better understanding of the serious nature of those decisions made in giving a child away and in receiving a child for adoption.



We note on the program of the Annual Meeting of the American Goitre Association, under the item "Annual Banquet", the statement, "Dress Optional." It must be fun to attend and discover who are the complete extroverts.

News Letter, A.S.A.

UNITED STATES NOW HAS RECORD 214,667 DOCTORS; 2,987 NET INCREASE

THERE were more physicians in the United States at the close of 1952—214,667—than at any other time in its history, it was disclosed in the 51st annual medical licensure report of the Council on Medical Education and Hospitals of the American Medical Association.

During 1952, 6,816 persons were licensed to practice medicine in this country for the first time. During the same period, 3,829 deaths of physicians were reported to the A.M.A., giving a net increase of 2,987 in the physician population of the nation. In 1951, an increase of 2,640 was reported.

In the 18-year-period from 1935 to 1952, there have been 110,700 additions to the medical profession. This is the result of the increase in the production of physicians under accelerated programs in medical schools, expanded facilities and the licensure of foreign-trained physicians, the report stated.

Of the total number of physicians in the United States at the close of 1952, 151,363 were engaged in private practice, 6,677 were in full-time research and teaching, 28,366 were interns, residents, and physicians engaged in hospital administration, 8,166 were retired or not in practice, and 20,095 were in the government services.

Medical licensure in this country is a "state right" and is entirely under the jurisdiction of the governments of the individual states, it was emphasized by Dr. Donald G. Anderson, Chicago, secretary of the council. The report, which appears in the current (May 30) *Journal of the American Medical Association*, was prepared by Dr. Anderson and Mrs. Anne Tipner, Chicago, a member of the council's staff.

"It is the function of the individual states to determine who shall practice within their borders and to maintain high standards of medical practice in accordance with their own rules and regulations," Dr. Anderson stated. "The power to license physicians is exercised through the medical licensing boards of each state."

A total of 13,228 licenses to practice medicine were issued in the continental United States, its

possessions and its territories during 1952; this included 6,885 issued to persons for the first time. The remainder were issued to physicians who moved their practice from one state to another. These licenses were issued upon examination or certification of credentials.

The greatest number of licenses, 1,581, were issued in California. New York licensed 1,292 physicians, and more than 500 licenses were issued in Florida, Illinois, Ohio, Pennsylvania, and Texas. Delaware, Maine, Montana, Nevada, North Dakota, South Dakota, Vermont and Wyoming each issued less than 50.

The high rating of the nation's 72 approved four-year medical schools was emphasized by the number of candidates who successfully passed examinations. Of the 5,434 graduates of approved medical schools in the United States, 97.3 per cent passed. Of the 128 graduates of approved schools in Canada, 93 per cent passed. In comparison, of the 1,208 graduates of foreign medical faculties, only 53.7 per cent passed; only 26.7 per cent of the 60 graduates of the now extinct unapproved medical schools in the United States passed, and 80.4 per cent of the 194 graduates of schools of osteopathy passed.

In February, 1950, the Council on Medical Education and Hospitals of the A.M.A. and the Executive Council of the Association of American Medical Colleges first published a list of foreign medical schools whose graduates they recommended for consideration on the same basis as graduates of approved medical schools in the United States and Canada, the report pointed out. Today, there are 50 such schools in 14 countries on the list.

In 1936, the number of foreign-trained physicians seeking licensure to practice in the United States began to increase, and by 1940 over three times as many were tested as in 1936, the report stated. Beginning in 1944, the number began to decrease; in 1951 and 1952 there was a noticeable increase again. At no time did fewer than 30.7 per cent of these foreign-trained examinees fail in a given year.

At the present time, nine states will not license foreign-trained physicians, according to the re-

port. The remainder of the states have various stipulations that must be complied with prior to licensure.

During 1952, 1,208 foreign-trained persons were examined for licenses to practice medicine in the United States. Those who were successful numbered 648; failures numbered 560, or 46.3 per cent. New York examined the greatest number, 427, of whom 171 passed; Illinois examined

313, of whom 153 passed, and California examined 143, 98 of whom passed.

During the last three years, 1,531 foreign-trained physicians were licensed to practice medicine in the United States. This is evidence of the efforts of those administering medical licensure to give every consideration to the qualified foreign-trained physician, and, at the same time, uphold the high standards of medical licensure in this country, the report stated.



Penicillin Treatment for VD To End, Burney Reports

For something over two years, the Indiana State Board of Health has been administering a program under which penicillin is provided to physicians for the treatment of syphilis in the medically indigent. This program was established by the Venereal Disease Committee of the Indiana State Medical Association and the State Board of Health.

Doctor L. E. Burney of the State Board of Health has recently announced that because of budgetary limitations, this program will be discontinued. The Board of Health still has on hand a small supply of penicillin for this purpose. When this supply is exhausted, the shortage of funds makes it mandatory that it cannot be replaced.

Bicycle accidents take approximately 600 lives a year in the United States, two thirds of them occurring between May and October.

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535 North Dearborn Street

Chicago 10, Illinois

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Rosters of Indiana State Medical Association officers, District and County Medical Society officers and other organizational information are listed on Pages 576, 578 and 580.

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Secretary-Treasurer—C. J. McIntyre, M.D., 414 Hume Mansur Bldg., Indianapolis 4.

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President—Meredith B. Flanigan, M.D., 2920 W. 33rd St., Indianapolis 22.

Secretary-Treasurer—V. K. Stoelting, M.D., I.U. Medical Center, Indianapolis 7.

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

President—Robert A. Smith, M.D., 1229 Lincoln Ave., Newcastle.

President-elect—C. P. Clark, M.D., 922 Hume Mansur Bldg., Indianapolis 4.

Vice-president—Raymond R. Calvert, M.D., 314 N. Sixth, Lafayette.

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Editor of The Transactions—Kenneth L. Craft, M.D., 1002 Hume Mansur Bldg., Indianapolis 4.

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Master of Exhibits—William E. Barb, D.D.S., Indianapolis.

Editor of Journal—H. C. Dimmich, D.D.S., Fort Wayne.

Supervisor of Clinics—E. A. W. Montgomery, D.D.S., Evansville

Executive Committeeman—Maynard Hine, D.D.S., Indianapolis.

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1101 West Tenth Street, Indianapolis 7

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1919 North Meridian St., Indianapolis 2

State Representative, Northern District—Edgar T. Britton.**State Representative, Southern District**—Robert H. Branson.**INDIANA PUBLIC HEALTH ASSOCIATION****President**—F. R. Nicholas Carter, 605 Sherland Bldg., South Bend.**President-Elect**—Prof. Don E. Bloodgood.**Vice-President**—Mrs. Gordon Johnson, VA Hospital, Indianapolis.**Secretary**—Hester Beth Bland, Indiana State Board of Health, Indianapolis.**Treasurer**—Cecilia Shook, Department of Home Economics, Purdue University, Lafayette.

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President—Evelyn Marsh, I.U. Medical Center, Indianapolis 7.

Vice-President—Alice Kennedy, Norman Beatty Hospital, Westville.

Treasurer—Anna May Eastlack, General Hospital, Indianapolis.

Secretary—Mrs. Marjorie Hillsman, Cerebral Palsy Clinic, Riley Hospital, Indianapolis.

INDIANA CHAPTER, AMERICAN PHYSICAL THERAPY ASSOCIATION

President—Geraldine Arnold, Veterans Administration Hospital, 1481 W. Tenth St., Indianapolis.

Vice-President—Ruth Denny, 204 E. Church St., Alexandria.

Secretary—Barbara Nash, 303 Broadway, Indianapolis.

Treasurer—Virginia Van Arch, Riley Hospital, Indianapolis.

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President—Gerald Eastburg, 719 Madison, Rochester.

First Vice-President—Rue M. Morgan, 1408 E. Main, Muncie.

Second Vice-President—Ida Miller, 2301 Adams St., Gary.

Secretary—Della Ingle Smith, 521 SE First, Evansville.

Treasurer—Frank N. Wilson, R. R. 1, Pierceton.

INDIANA STATE MEDICAL, DENTAL AND PHARMACEUTICAL ASSOCIATION

President—Edward L. C. Broomes, M.D., East Chicago.

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Treasurer—Frank W. Chowning, D.D.S., Indianapolis.

Secretary—Dennis A. Bethea, M.D., Hammond.

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First Vice-President—Mrs. Ruth Spradley, Indianapolis.

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Treasurer—Mrs. Jennie Jones, Wabash.

Secretary—Mrs. Dorothy Slaton, 2516 N. Lafayette Ave., Evansville.

INDIANA STATE NURSES' ASSOCIATION

302-3 Terminal Bldg., Indianapolis 4

President—Miss Helen J. Weber, Division of Nursing Education, Bloomington.

First Vice-President—Miss Mildred Adams, 1415 E. 3rd St., No. 111, Bloomington.

Second Vice-President—Miss Elsie Norman, Protestant Deaconess Hospital, Evansville.

Treasurer—Miss Edna M. DeBruler, R.N., 3812 N. Pennsylvania St., Indianapolis.

Secretary—Miss Clara May Miller, R.N., 2400 University Ave., Muncie.

Executive Secretary—Miss E. Nancy Scramlin, R.N., 302-3 Terminal Bldg., Indianapolis 4.

Professional Counseling and Placement Service, Inc.—Miss Edwina MacDougall, R.N., Consultant, 302-3 Terminal Bldg., Indianapolis 4.

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Vice-President—Mrs. Mildred Ellis, Terre Haute

Secretary—Miss Thelma Koontz, Fort Wayne

Treasurer—Miss Ruth Scott, Fort Wayne

Directors—Miss Martha E. Warstler, Muncie; Paul Bergevin, Bloomington; Sister Clare, Dr. Martha O'Malley, Roscoe Clark, Indianapolis.

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Senior Senator—Hon. Homer E. Capehart.
(R) Washington, Indiana.
Junior Senator—Hon. William E. Jenner.
(R) Bedford, Indiana.

* Address them at Senate Office Building,
Washington, D. C.

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First District—Hon. Ray J. Madden.
(D) 578 Broadway, Gary.
Second District—Hon. Charles A. Halleck.
(R) Rensselaer.
Third District—Hon. Shepard J. Crumpacker.
(R) 1906 Bergan St., South Bend.
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Seventh District—Hon. William Bray.
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(R) 119 S. Meridian St., Indianapolis.

† Address them at House Office Building,
Washington, D. C.

ELECTED STATE OFFICIALS

Office	Incumbent	Politics	Room Number
Governor	George N. Craig	R	206
Lieutenant Governor	Harold W. Handley	R	331
Secretary of State	Crawford F. Parker	R	201
Treasurer of State	John Peters	R	242
Auditor of State	Frank T. Millis	R	238
Attorney General	Edwin K. Steers	R	219
Supt. of Public Instruction	Wilbur Young	R	227
Clerk of Supreme Court	Thomas C. Williams	R	217
Reporter of Supreme Court	Virginia B. Caylor	R	416

We Are Sorry!

It is with regret that THE JOURNAL is eliminating the roster of Indiana State Boards and the list of Institutions Operated by the State of Indiana together with names of their administrators from the 1953-54 Medical Yearbook. This section has been a regular feature of the Yearbook since its establishment.

We have delayed printing of the Yearbook far beyond the regular deadline and have made every possible effort to obtain a current, official list of these names of interest to the medical profession. We were informed by the Governor's office that this material would be available to us by June 25. Not all appointments have been made. Rather than print obsolete, incorrect information we are dropping the section.

THE JOURNAL has been assured that this material will be ready for use in the August issue.

Whenever an official list of appointments is received from the State of Indiana it will be published in THE JOURNAL for the convenience of members of the Indiana State Medical Association.

APPROVED HOSPITALS IN INDIANA*

June 1, 1953

ADAMS COUNTY

Blanche L. Krick, Adm.
Adams County Memorial Hospital.
804 Mercer Ave., Decatur.

ALLEN COUNTY

Mr. Donald C. Carner, Adm.
Fort Wayne Methodist Hospital, Inc.
119 W. Lewis St., Fort Wayne.
O. T. Kidder, M.D., Adm. & Med. Dir.
Irene Byron Sanatorium.
R. R. 13, Lima Road North, Fort Wayne
Mr. E. C. Moeller, Adm.
The Lutheran Hospital of Fort Wayne.
3024 Fairfield Ave., Fort Wayne.
Sister M. Augusta, R.N., Adm.
St. Joseph Hospital.
730 W. Berry St., Fort Wayne.

BARTHOLOMEW COUNTY

Miss Olive M. Murphy, R.N., Adm.
Bartholomew County Hospital.
East 17th St., Columbus.

BLACKFORD COUNTY

Mrs. Doris M. Wright, Acting Adm.
Blackford County Hospital.
503 E. Van Cleve St., Hartford City.

BOONE COUNTY

Mrs. Lottie M. Dodson, Adm.
Witham Memorial Hospital.
1124 N. Lebanon St., Lebanon.

CASS COUNTY

Miss Macie N. Knapp, R.N., Adm.
Memorial Hospital.
1101-1115 Michigan Ave., Logansport.
Sister Joachime, Adm.
St. Joseph Hospital.
26th and North Sts., Logansport.

CLARK COUNTY

Mr. William McAlexander, Adm.
Clark County Memorial Hospital.
210 Sparks Ave., Jeffersonville.

CLAY COUNTY

Miss Helen L. Broughton, R.N., Adm.
Clay County Hospital.
1206 E. National Ave., Brazil.

CLINTON COUNTY

Miss Maude M. Woodard, R.N., Adm.
Clinton County Hospital.
1300 S. Jackson St., Frankfort.

DAVISS COUNTY

Mrs. Olive B. DeHart, R.N., Adm.
Daviess County Hospital.
1307 Bedford Road, Washington.

DECATUR COUNTY

Miss Juliana K. Huser, R.N., Adm.
Decatur County Memorial Hospital.
720 N. Lincoln St., Greensburg.

DEKALB COUNTY

Bonnell M. Souder, M.D., Adm.
Dr. Bonnell M. Souder Hospital.
206 W. 7th St., Auburn.
Sister M. Daniela, Adm.
Sacred Heart Hospital.
220 S. Ijams St., Garrett.
Jesse A. Sanders, M.D., Adm.
Sanders General Hospital.
1007 S. Main St., Auburn.

DELAWARE COUNTY

Mr. Walter G. Ebert, Adm.
Ball Memorial Hospital.
2401 University Ave., Muncie.

DUBOIS COUNTY

Sister Mary James, Adm.
The Stork Memorial Hospital.
530 4th St., Huntingburg.
Mother M. Catherine, Adm.
Memorial Hospital of Dubois County.
800 West 9th St., Jasper.

ELKHART COUNTY

Mr. Emery K. Zimmerman, Adm.
Elkhart General Hospital.
1100 South Boulevard, Elkhart.
Mrs. Lois Sinner Ulery, Adm.
Goshen Hospital.
112-116 N. 5th St., Goshen.

FAYETTE COUNTY

Mr. J. W. Myers, Adm.
Fayette Memorial Hospital.
1941 Virginia Ave., Connersville.

FLOYD COUNTY

Sister M. Joan, R.N., Adm.
St. Edward Hospital.
701 E. Spring St., New Albany.
J. V. Pace, M.D., Adm.
Silvercrest.
(Southern Indiana Tuberculosis Hospital)
New Albany.

FULTON COUNTY

Miss Bernice I. Rannels, R.N., Adm.
Woodlawn Hospital.
624 Pontiac St., Rochester.

GIBSON COUNTY

Mrs. Dorothy G. Adams, R.N., Adm.
Gibson General Hospital.
419 W. State St., Princeton.
M. A. Turner, M.D., Adm.
Oakland City Hospital.
211 N. Gibson St., Oakland City.

* Approved by the Indiana Council for Hospital Licensure and the Indiana State Board of Health.

GRANT COUNTY

Miss Amy J. Daniels, Adm.
Marion General Hospital.
 Wabash and Euclid, Marion.

GREEN COUNTY

Mr. Avery Murray, Adm.
Freeman Greene County Hospital.
 410 "A" St., N.E., Linton.

HAMILTON COUNTY

Miss Kittie McKelvey, R.N., Adm.
Riverview Hospital.
 R.R. 4, Noblesville, Ind.

HANCOCK COUNTY

Mr. Harold Himelick, Adm.
Hancock County Memorial Hospital.
 800 North Street, Greenfield.

HARRISON COUNTY

Miss Elizabeth Browne, R.N., Adm.
Harrison County Hospital.
 Corydon.

HENRY COUNTY

Mr. Herbert A. Schacht, Adm.
Henry County Hospital.
 Rural St., New Castle.
 Walter M. Stout, M.D., Adm.
The Clinic.
 1319 Church St., New Castle.

HOWARD COUNTY

Sister Ann Rita, Adm.
St. Joseph Memorial Hospital.
 1907 W. Sycamore St., Kokomo.

HUNTINGTON COUNTY

Mr. Charles E. Paul, Adm.
Huntington County Hospital.
 1215 Etna Ave., Huntington.

JACKSON COUNTY

Mr. Ralph W. Keyes, Adm.
Jackson County Schneck Memorial.
 Bruce and Poplar St., Seymour.

JASPER COUNTY

Mrs. Ruth Schumaker, R.N., Adm.
Jasper County Hospital.
 216-224 S. Cullen St., Rensselaer.

JAY COUNTY

Mr. Lynn L. Landis, Adm.
Jay County Hospital.
 505 W. Arch St., Portland.

JEFFERSON COUNTY

Mrs. Rinda F. Rains, R.N., Adm.
King's Daughters' Hospital.
 112 Presbyterian Ave., Madison.

JOHNSON COUNTY

Miss Ruth Legan, Adm.
Johnson County Memorial Hospital.
 R.R. 1, Franklin.

KNOX COUNTY

Miss Dee Elsome, Adm.
Good Samaritan Hospital.
 410 S. 7th St., Vincennes.
 R. C. Meyer, M.D., Adm.
Hillcrest Tuberculosis Hospital.
 North 2nd St. Road, Vincennes.

KOSCIUSKO COUNTY

Miss Coral Anderson, Adm.
McDonald Hospital.
 Center and Argonne Road, Warsaw.
 Mrs. Samuel C. Murphy, Adm.
Murphy Medical Center.
 101 W. Winona Ave., Warsaw.

LAGRANGE COUNTY

Miss Edythe L. Gappinger, R.N., Adm.
LaGrange County Hospital.
 LaGrange.

LAKE COUNTY

Philip H. Becker, M.D., Adm.
James O. Parramore Hospital.
 R. R. 5, Crown Point.
 Mr. George R. Wren, Adm.
The Methodist Hospital of Gary, Inc.
 1600 W. 6th Ave., Gary.
 Sister Teresa Marie, R.N., Adm.
Our Lady of Mercy Hospital.
 Lincoln Highway and Joliet St., Dyer.
 Sister M. Vetusa, R.N., Adm.
St. Catherine Hospital.
 4321 Fir St., East Chicago.
 Sister M. Flaviana, R.N., Adm.
St. Margaret Hospital.
 25 Douglas St., Hammond.
 Sister M. Milburg, R.N., Adm.
St. Mary's Mercy Hospital.
 540 Tyler St., Gary.

LAPORTE COUNTY

Mr. Ernest I. Hoover, Adm.
Fairview Hospital Association, Inc.
 215 Pine Lake Ave., LaPorte.
 M. L. Bankoff, M.D., Adm.
Doctor's Hospital.
 125-133 E. 5th St., Michigan City.
 Sister M. Reinolda, R.N., Adm.
Holy Family Hospital.
 205 "E" St., LaPorte.
 Sister M. Albertinia, R.N., Adm.
St. Anthony Hospital.
 Wabash and Ann Sts., Michigan City.
 Mr. Stanley E. Giese, Adm.
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Dunn Memorial Hospital.
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Mercy Hospital.
 1331 South "A" St., Elwood.
 Sister M. Petronilla, Adm.
St. John's Hickey Memorial Hospital.
 127 W. 19th St., Anderson.
 Miss Clara M. Lenz, R.N., Adm.
Citizens Nursing Center.
 431 Citizens Bank, Anderson.

MARION COUNTY

Gerald F. Kempf, M.D., Adm.
Indianapolis General Hospital.
 960 Locke St., Indianapolis.
 Mr. Edmund J. Shea, Adm.
James Whitcomb Riley Hospital for Children.
 I. U. Medical Center, 1040-1232 W. Michigan St., Indianapolis.
 Mr. Robert E. Neff, Adm.
Methodist Hospital of Indiana, Inc.
 1604 N. Capitol Ave., Indianapolis.
 Mr. Edmund J. Shea, Adm.
Robert W. Long Hospital.
 I. U. Medical Center, 1040-1232 W. Michigan St., Indianapolis.
 Very Rev. August R. Fussenegger, Adm.
St. Elizabeth's Maternity Hospital and Infant Home.
 2500 Churchman Ave., Indianapolis.
 Sister M. Alexia, Adm.
St. Francis Hospital.
 Sherman Drive and Troy Ave., Beech Grove.
 Sister Lydia, Adm.
St. Vincent's Hospital.
 120 W. Fall Creek Parkway, Indianapolis.
 Mrs. Ruth Henderson, Adm.
Suemma Coleman Home.
 2044 N. Illinois St., Indianapolis.
 Frank L. Jennings, M.D., Adm.
Marion County Tuberculosis Hospital.
 Sunnyside Sanatorium, R.R. 12, Box 233, Indianapolis.
 Mr. Edmund J. Shea, Adm.
William H. Coleman Hospital for Women.
 I.U. Medical Center, 1040-1232 W. Michigan St., Indianapolis.

MARSHALL COUNTY

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Community Hospital of German Township, Inc.
 411 Grant St., Bremen.
 Miss Lela Diefenbaugh, R.N., Adm.
Parkview Hospital.
 1401 N. Michigan St., Plymouth.

MIAMI COUNTY

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Dukes-Miami County Hospital.
 12th and Grant Sts., Peru.
 Mr. W. E. Gollings, Adm.
Wabash Employees Hospital Association.
 North Broadway, Peru.

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Bloomington Hospital.
 640 S. Rogers St., Bloomington.

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Montgomery County Culver Union Hospital.
 308 Binford St., Crawfordsville.

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 130 N. Indiana St., Mooresville.
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Morgan County Memorial Hospital.
 190 S. Main St., Martinsville.

NOBLE COUNTY

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Luckey Hospital.
 Wolflake.
 Sister M. Joseph, Adm.
Kneipp Springs Sanatorium.
 Rome City.
 Mrs. Beulah J. Burns, R.N., Adm.
McCray Memorial Hospital.
 Hospital Drive, Kendallville.

ORANGE COUNTY

Ivan A. Clark, M.D., Adm.
Paoli Hospital Foundation, Inc.
 308 E. Main St., Paoli.

PARKE COUNTY

Robert A. Staff, M.D., Adm.
Indiana State Sanatorium.
 R.R. 1, Rockville.

PERRY COUNTY

Robert G. Gilbert, M.D., Adm.
Perry County Memorial Hospital.
 Star Route, Tell City, Ind.

PORTER COUNTY

Mr. R. Edwin Hawkins, Adm.
Porter Memorial Hospital.
 814 LaPorte Ave., Valparaiso.

PULASKI COUNTY

Thomas E. Carneal, M.D., Adm.*
Carneal's Private Hospital.
 111 N. Monticello St., Winamac.

PUTNAM COUNTY

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Putnam County Hospital.
 322 Greenwood Ave., Greencastle.

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Randolph County Hospital.
 Oak Street, Winchester.
 Miss Kathryn E. Larrance, Adm.
Union City Hospital.
 702 W. Division St., Union City.

RIPLEY COUNTY

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Margaret Mary Hospital.
 Rosemont Division, Batesville.
 William J. Warn, M.D., Adm.*
The Whitlatch Clinic and Hospital, Inc.
 Milan.

RUSH COUNTY

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Rush Memorial Hospital.
 Main at 13th St., Rushville.

* License pending until certain noncompliances are met.

SCOTT COUNTY

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Napper Hospital.
69 Wardell St., Scottsburg.

SHELBY COUNTY

Mrs. Frances Pruitt, R.N., Adm.
William S. Major Hospital.
150 W. Washington St., Shelbyville.

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E. W. Custer, M.D., Adm.
Healthwin Hospital.
1111 West Darden Road, South Bend.
Mr. Alvan A. Sauer, Adm.
Northern Indiana Children's Hospital.
1234 N. Notre Dame Ave., South Bend.
Mr. Richard W. Trenkner, Adm.
Memorial Hospital of South Bend.
604 N. Main St., South Bend.
Sister M. Reginalda, R.N., Adm.
St. Joseph Hospital.
1215 W. 4th St., Mishawaka.
Sister Miriam Dolores, R.N., Adm.
St. Joseph's Hospital.
401 N. Notre Dame Ave., South Bend.
A. F. Kull, D.O., Adm.
South Bend Osteopathic Hospital.
118 S. William St., South Bend.

STARKE COUNTY

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Starke Memorial Hospital.
Culver Road, Knox.

STEBEN COUNTY

Mrs. Daisy McCallister, R.N., Adm.
Cameron Hospitals, Inc.
416 E. Maumee, Angola.
Miss Bessie Cottrell, R.N., Adm.
Elmhurst Hospital, Inc.
609 W. Maumee, Angola.

SULLIVAN COUNTY

Miss Mabel A. Cook, R.N., Adm.
Mary Sherman Hospital.
320 N. Section St., Sullivan.

TIPPECANOE COUNTY

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Lafayette Home Hospital.
2400 E. South St., Lafayette.
Sister M. Vera, Adm.
St. Elizabeth Hospital.
1021 N. 14th St., Lafayette.
J. W. Strayer, M.D., Adm.
William Ross Sanatorium.
R.R. 6, State Road No. 52, Lafayette.

TIPTON COUNTY

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Tipton County Memorial Hospital.
South Main Street, Tipton.

VANDEBURGH COUNTY

Paul D. Crimm, M.D., Adm.
Boehne Tuberculosis Hospital.
Upper Mount Vernon Road, Zone 12, Evansville.

Albert G. Hahn, L.H.D., Adm.
Protestant Deaconess Hospital.
600-700 Mary St., Evansville.
Sister Justina, Adm.
St. Mary's Hospital, Inc.
713 First Ave., Evansville.
Mr. Crayton E. Mann, Adm.
Welborn Memorial Baptist Hospital, Inc.
412 S.E. 4th St., Evansville.

VERMILLION COUNTY

Miss Hannah Rosser, R.N., Adm.
Vermillion County Hospital.
800 S. Main St., Clinton.

VIGO COUNTY

Mrs. Arlie L. Dwyer, R.N., Adm.
Florence Crittendon Home and Hospital.
1923 Poplar St., Terre Haute.
Hoover Sanatorium.
2144 8th Ave., Terre Haute.
Sister M. Ludolpha, Adm.
St. Anthony Hospital.
1021 S. 6th St., Terre Haute.
I. Herman Sloss, M.D., Adm.
Sloss Hospital.
1029 S. 7th St., Terre Haute.
Ellen E. Church, R.N., Adm.
Union Hospital, Inc.
7th St. at 8th Ave., Terre Haute.

WABASH COUNTY

Mrs. E. A. Ford, Actg. Adm.
Wabash County Hospital.
670 N. East St., Wabash.

WARREN COUNTY

Mrs. Nellie O. Rudolph, Adm.
The Community Hospital.
412 N. Monroe St., Williamsport.

WASHINGTON COUNTY

Mr. Frank R. Elrod, Adm.
Washington County Memorial Hospital.
Shelby Street, Salem.

WAYNE COUNTY

Mr. Frank G. Sheffler, Adm.
Reid Memorial Hospital.
Spring Grove, Richmond.
J. Nelson Ewbank, M.D., Adm.
Smith Esteb Memorial Hospital.
R. R. No. 4, Liberty Pike, Richmond.

WELLS COUNTY

Mrs. Eileen Stipp, Adm.
Clinic Hospital.
309 S. Main St., Bluffton.
Mrs. Clara Steiner, Adm.
Wells County Hospital.
1116 S. Main St., Bluffton.

WHITLEY COUNTY

Mr. Carl F. Arnston, Adm.
Memorial Hospital.
215 E. Van Buren St., Columbia City.
Mr. Stanley S. Mullendore, Adm.
Whitley County Memorial Hospital.
353 N. Oak St., Columbia City.

ACCREDITED SCHOOLS OF NURSING

School of Nursing and Hospital, University or College with which School is connected		Location	Director, School of Nursing	Daily Patient Census
*a	St. John's Hickey Memorial	Anderson	Sister Anne Miriam, R.N.	206
	Protestant Deaconess	Evansville	Miss Elsie Norman, R.N.	238.8
	St. Mary's	Evansville	Sister Georgiana, R.N.	154.5
	Welborn Memorial Baptist	Evansville	Mrs. Madeline T. Kinney, R.N.	114
a	Lutheran	Fort Wayne	Miss Myrtle E. Lewis, R.N.	200
	Methodist	Fort Wayne	Miss Marie Kolter, R.N.	110
	St. Joseph	Fort Wayne	Sister M. Theodorita, R.N.	255.5
	Methodist ¹	Gary	Miss Marcia J. Aitkens, R.N.	242
	St. Mary Mercy ¹	Gary	Sister M. Cornelia, R.N.	212
xxxb	Goshen College	Goshen	Miss Orpah B. Mosemann, R.N., Act'g.	
	St. Margaret ¹	Hammond	Sister M. Florianne, R.N.	238
a	Indiana University	Indianapolis	Miss Jean L. Coffey, R.N.	536
a	Indianapolis General	Indianapolis	Miss Elizabeth C. Wivel, R.N.	562
b	Methodist	Indianapolis	Miss Fredericka E. Koch, R.N.	637.5
	St. Vincent's	Indianapolis	Sister Clare, R.N.	318
*a	Good Samaritan School,			
	St. Joseph Memorial Hospital	Kokomo	Sister M. Bernadette, R.N.	140
	Lafayette Home	Lafayette	Miss Lucille H. Johnson, R.N.	111.4
a	St. Elizabeth ¹	Lafayette	Sister M. Florina, R.N.	224
	Ball Memorial	Muncie	Miss Clara May Miller, R.N.	265.5
a	Holy Cross Central School	Notre Dame	Sister M. Amadeo, R.N.	
Hospital Units:				
	St. John's Hickey Memorial			
	Hospital	Anderson		206
	St. Joseph Hospital	Kokomo		140
	St. Joseph Hospital	South Bend		144
	St. Mary's Hospital	Cairo, Illinois		65
	Our Savior's Hospital	Jacksonville, Illinois		76
xxxa	St. Mary's College	Notre Dame	Sister M. Amadeo, R.N.	
	Reid Memorial	Richmond	Miss Prudence Appelmann, R. N.	138
	Memorial Hospital ¹	South Bend	Miss Florence Young, R.N.	202
*a	St. Joseph's	South Bend	Sister M. Cecilian, R.N.	144
a	St. Anthony	Terre Haute	Sister M. Delphina, R.N.	156
	Union	Terre Haute	Miss Ellen R. Church, R.N.	158
	Good Samaritan	Vincennes	Miss Faith Smith, R.N.	190

a Negro students are enrolled.

b will accept male students.

* students are admitted through Holy Cross Central School.

xxx collegiate school of nursing.

1—Temporarily accredited—1953.

LICENSED NURSING HOMES IN INDIANA

(As of June 1, 1953)

ADAMS COUNTY

Berne Nursing Home
906 W. Main St., Berne
Miss Pauline Hostetler
Decatur Nursing Home
1038 N. Second St., Decatur
Walter and Maxine Winchester,
R.N.

ALLEN COUNTY

Colonial Nursing Home
802 W. Berry St., Fort Wayne
Miss Inez Gross, R.N.
Crater Nursing Home
1407 E. Wayne St., Fort Wayne
Mrs. Pearl Crater
"Crow's Haven"
2440 Bowser St., Fort Wayne
Mrs. Meta Crow
Grace Convalescent Home
1529 California Ave., Fort
Wayne
Mrs. Jessie G. Richer
Lawton Nursing Home
1649 Spy Run Ave., Fort Wayne
Mr. Walter C. Buuck
Munson Home
336 Madison St., Fort Wayne
Mrs. Mabel Munson
Twin Maples Sanitarium
734 W. Washington Blvd., Fort
Wayne
Mrs. Maude M. Cole, R.N.
West Berry Street Rest Home
903 W. Berry St., Fort Wayne
Herbert E. Atkinson, Sr.
Yerrick Home for Men
516 W. Third St., Fort Wayne
Gladys and Joe Sweeney

BARTHOLOMEW COUNTY

Brown Nursing Home
318 Smith St., Columbus
Mr. Ithamer Brown
Columbus Nursing Home
213 Fourth St., Columbus
Mrs. Lorene Graham
Redman's Sanitarium
R. R. 4, Columbus
Frank A. and Nellie D. Redman
Shanklin Nursing Home
705 Sycamore St., Columbus
Mrs. Mildred Shanklin

BENTON COUNTY

Neal Nursing Home
3rd and Maple Sts., Earl Park
Mrs. Genevieve L. Neal

Ellsworth Nursing Home
Smith St., Oxford
Mrs. Bertha Ellsworth

BLACKFORD COUNTY

Anderson Nursing Home
134 W. Green St., Montpelier
Mrs. Cora N. Anderson
Waldo House
511 W. Washington St.,
Hartford City
Mrs. Martha Waldo
Jackson Convalescent Home
423 S. Main St., Montpelier
Rolland W. Jackson

BOONE COUNTY

Cora's Nursing Home
121-123 S. East St., Lebanon
Mrs. Cora Nelson
English Nursing Home
304 W. Washington St., Lebanon
Mrs. Bessie M. English
Trammel Nursing Home
415 N. Clark St., Lebanon
Mrs. Sarah S. Trammel
Davis Nursing Home
310 W. Main St., Thorntown
Mrs. Ruth Davis
Fultz Nursing Home
40 N. Third St., Zionsville
Mrs. Bertha Fultz

CARROLL COUNTY

Deer Creek Nursing Home
R. R. 1, Camden
Miss Mabel E. Bechdolt
Good Will Nursing Home
Corner Main and Monroe Sts.,
Camden
Miss Mabel E. Bechdolt
Cornell Nursing Home
R. R. 1, Cutler
Mrs. Victoria Cornell
Porter Nursing Home
616 E. Monroe St., Delphi
Mrs. Alsie J. Porter
The Arzula Flora Nursing Home
312 W. Main St., Flora
Miss Ida Arzula Flora
Mamie Kennedy Nursing Home
404 S. Center St., Flora
Mrs. Mamie Kennedy

CASS COUNTY

Effie Bell Nursing Home
R. R. 2, W. Jackson, Galveston
Mrs. Effie Bell

Galveston Nursing Home

Washington & Sycamore Sts.,
Galveston
Estie and Ednabelle Bell
Huffman Nursing Home
2533 E. Broadway, Logansport
Mrs. Honour Ruth Huffman
Justice Nursing Home
227 Cliff Dr., Logansport
Mr. and Mrs. Martin Justice
Rest Haven Nursing Home
731 North St., Logansport
Miss Olive S. Jones
Rose Lawn Home
3026 E. Broadway, Logansport
Miss Marie Wilsie Thomas
Bird's Home
R. R. 2, Royal Center
Mrs. Irene Bird
Flo Dodt Nursing Home
Royal Center
Mrs. Flo Dodt

CLARK COUNTY

Griggs Nursing Home
208 W. Riverside Dr., Jefferson-
ville
Mrs. Mary C. Griggs
Keller Home
403 E. 7th St., Jeffersonville
Mrs. Florence Keller
Maple Court Nursing Home
Maple Court, Box 29,
Jeffersonville
Mrs. Grace Stofel
Pleasant Nursing Home
1315 Spring St., Jeffersonville
Leonard R. Pleasant
Twilight Nursing Home
210 E. Maple St., Jeffersonville
Mrs. Delilah Jean Goodwin

CLAY COUNTY

Bridgewater Nursing Home
525 E. Mechanic St., Brazil
Mrs. Goldie Bridgewater
Dove Dell Rest Home
36 N. Forest St., Clay City
Mrs. Josephine Lowe

CLINTON COUNTY

Colfax Nursing Home
P.O. Box 826, Main St., Colfax
Mrs. Francis M. Waggoner
Ashley Nursing & Convalescent Home
R. R. 6, Frankfort
Mrs. Jean Ashley Hladik

Harriet Ann Stoker Nursing Home
R. R. 4, Frankfort
Mrs. Harriet Ann Stoker

DAVIESS COUNTY

Baker's Nursing Home
819 Axtell Ave., Washington
Mrs. Rose Ann Baker
Colvin's Nursing Home
1109 National Highway,
Washington
Mrs. Laura Colvin
Colvin's Convalescent Home
307 Harnard Ave., Washington
Mrs. Laura Colvin
Meyers Nursing Home
215 W. Oak St., Washington
Mrs. John Meyers

DEARBORN COUNTY

Voshell Nursing Home
R. R. 1, Aurora
Mrs. Purnell Voshell

DECATUR COUNTY

The Black Nursing Home
619 W. Main St., Greensburg
Mrs. Pearl Black
Davis Nursing Home
510 W. Washington St.,
Greensburg
Mrs. Edith Davis
Michigan Hill Nursing Home
320 S. Michigan Ave.,
Greensburg
Mrs. Mary Clifton
The Ridout Nursing Home
410 S. Broadway, Greensburg
Mrs. Lila Ridout
Jessup Nursing Home
Westport
Mrs. Myrtle Jessup

DEKALB COUNTY

Brouse Nursing Home
R. R. 2, Butler
W. H. and Susie M. Brouse
Cox Nursing Home
R. R. 2, Butler
Mrs. Mary Cox
Williams Convalescent Home
402 N. Broadway, Butler
R. E. and Pauline Williams
Williams Nursing Home #2
610 S. Broadway, Butler
R. E. and Pauline Williams
Garrett Convalescent Home
611 S. Peters St., Garrett
Mr. and Mrs. Earle R. Saffen

DELAWARE COUNTY

Arlis Clark Nursing Home
South St., Eaton
Mrs. Arlis R. Clark

Freeman Nursing Home
1101 W. Powers St., Muncie
Mrs. Mamie Freeman
Goodman Nursing Home
618 N. Elm St., Muncie
Mrs. Edith Goodman
Morgan Convalescent Home
1408 E. Main St., Muncie
Mrs. Rue Ann Morgan and
Mrs. Lucy Mae Morgan
Ring Home
R. R. 7, Muncie
Mrs. Elizabeth Ring
Shady Haven Rest Home
R. R. 6, Muncie
Mrs. Leila C. Wilcox
Sylvester Home for the Aged
R. R. 5, Burlington Dr., Muncie
Mrs. Nellie V. Sylvester, R.N.
Williams Nursing Home
1525 S. Monroe St., Muncie
Mrs. Rena Williams
Woodland Home
917 E. Main St., Muncie
Mrs. Hazel Wilson, R.N.
Karcher Home
Selma
Mrs. Aida Karcher

DUBOIS COUNTY

Baker's Nursing Home
701 W. Seventh St., Jasper
Mrs. Rose Ann Baker

ELKHART COUNTY

Hope Convalescent Home
E. Vistula St., Bristol
Mrs. Bernice Alverson
Cora Shaum Nursing Home
901 S. Second St., Elkhart
Mrs. Cora Shaum
Florentine Convalescent Home
318 Beardsley Ave., Elkhart
Mrs. Florentine Warskow
Thorp Nursing Home
115 Washington St., Elkhart
Mrs. Ruth G. Thorp
The Austin Home
526 N. Sixth St., Goshen
Mr. and Mrs. Fred S. Austin
Coil Convalescent Home
225 S. 5th St., Goshen
Mrs. Wilma L. Coil
Holm Convalescent Home
807 N. Main St., Goshen
Mrs. Goldie Holm Rogers
Hutchinson Nursing Home
402 S. Sixth St., Goshen
Mrs. Irene Hutchinson
Lockerbie Nursing Home
302 E. Lincoln Ave., Goshen
Mrs. Jane Ketrang Barnes

Moore Nursing Home
401 S. Main St., Goshen
Mr. and Mrs. Ralph Moore
Riley Convalescent Home
527 S. Main St., Goshen
Albert and Eunice Riley
Weaver Convalescent Home
R. R. 5, Goshen
Mrs. Esther Weaver

FAYETTE COUNTY

Clifton Nursing Home #3
224 S. Eastern Ave.,
Connersville
Mrs. Mary Clifton
Lincoln Manor
903 Lincoln Ave., Connersville
Mr. Chester O'Neal

FLOYD COUNTY

Rest Haven Nursing Home
909-11 E. Spring St.,
New Albany
Mrs. Sara Roy Seebert

FOUNTAIN COUNTY

Maplewood Nursing Home
R. R. 4, Veedersburg
Mrs. Mable Butte and
Mrs. Maxine Brown

FRANKLIN COUNTY

The Resthaven Reifel Nursing Home
1015 Franklin St., Brookville
Mrs. Elizabeth A. Reifel

FULTON COUNTY

McFarland Nursing Home
816 Jefferson St., Rochester
Mrs. Ralph McFarland
Rochester Nursing Home #1
719 Madison St., Rochester
Mr. Gerald Eastburg
Rochester Nursing Home #2
1118 Main St., Rochester
Gerald Eastburg

GIBSON COUNTY

Shady Grove Nursing Home
Francisco
Mrs. Ruth Morris
Church Convalescent Home
417 W. Broadway, Princeton
Mrs. Edra E. Church
Hitch Convalescent Home
Patoka
Mrs. Ethel M. Hitch
Gorham's Private Rest Home
807 S. Main St., Princeton
Mrs. Amy Gorham

GRANT COUNTY

Bide-A-Wee Rest Home
910 N. Rush St., Fairmount
Mrs. Agnes Butcher

Friendship Heights

704 S. Main St., Fairmount
Mrs. Margaret Meyer

Smith's Nursing Home

R. R. 2, Fairmount
Arlene and Robert Smith

The Roberts Nursing Home

P.O. Box 102, Fowlerton
Mrs. Ethel Roberts

Frances' Nursing Home

1827 S. Adams St., Marion
Mrs. Frances Moore

Mrs. Lanter's Home

1649 W. Second St., Marion
Mrs. Anna Lanter

Peterson Nursing Home

1335 W. Nelson St., Marion
Mrs. Ida Peterson

Whiteman Nursing Home

148 N. Branson St., Marion
Mrs. B. E. Whiteman

Campbell Nursing Home

Box 53, Van Buren
Mrs. Bertha O. Campbell

HAMILTON COUNTY**Arcadia Rest Home**

S. School St., P.O. Box 28,
Arcadia

Mrs. Florence Sigler

Moore's Nursing Home

South St., Arcadia
Mrs. Anna Moore

Sunderman Nursing Home

Cass and Harrison Sts., Cicero
Mr. and Mrs. B. H. Sunderman

The Hamilton Home

R. R. 5, Noblesville
Mrs. Mary E. McKinley

HANCOCK COUNTY**Wood's Nursing Home**

14 N. Wood St., Greenfield
Mrs. Hazel E. Wood

Pleasant Acres

R. R. 12, Box 320, Indianapolis
Corner 56th & McCordsville Rd.
Mr. Frederick M. Burns

HENDRICKS COUNTY**Plainfield Nursing Home**

404 N. Vine St., Plainfield
Miss Lois B. Thompson

Perkins Nursing Home

64 N. Hight St., Danville
Mrs. Pearl Perkins

HENRY COUNTY**"The Boxwoods"**

115 N. 10th St., New Castle
Mrs. Margaret Harris

Homestead Nursing Home

Spiceland
Mr. and Mrs. William Whitacre

Castle Nursing Home

1122 S. 14th St., New Castle
Mrs. M. Conner

Rest Haven

420 S. Main St., New Castle
Mrs. Rebecca L. John

HOWARD COUNTY**Colonial Haven Nursing Home**

613 E. Superior St., Kokomo
Mrs. Mae Kennedy

Randle's Nursing Home

630 S. Union St., Kokomo
Mrs. Fern Randle

**Sunnyview Convalescent Home
#2**

705 N. Main St., Kokomo
Mrs. Mary DeVore Hess

Twilite Nursing Home

612 N. Webster St., Kokomo
Mrs. Daisy Coy

HUNTINGTON COUNTY**Davis Nursing Home**

207 Frederick St., Huntington
Mrs. Annette Davis

DeKoning Convalescent Home

R. R. 8, Huntington
Mrs. Ann Cecilia DeKoning

Jefferson Sanitarium

414 S. Jefferson St., Huntington
Herbert Earl Atkinson, Sr.

Moore Home

425 Hasty St., Huntington
Mrs. Maud Moore

Oak Park Sanitarium

743 N. Main St., Roanoke
Mrs. Fern N. Martin

JACKSON COUNTY**Roselawn Home**

202 W. 6th St., Seymour
Mrs. Esta T. Martin

JAY COUNTY**Downing Nursing Home**

124 W. North St., Portland
Mrs. Delsie M. Downing

Portland Nursing Home, Inc.

406 W. Arch St., Portland
Mrs. Elvie Councilman, R.N.

JEFFERSON COUNTY**Madison Nursing Home**

726 W. Main St., Madison
Mrs. Ella Shuell, R.N.

Glore Nursing Home

North Madison
Mrs. Flora Glore

Hilltop Rest Home

Box 67, North Madison
Mrs. Susan Obertate

JOHNSON COUNTY**Johnson Nursing Home**

651 S. State St., Franklin
Mrs. Janie Johnson

McKee's Nursing Home

400 Kentucky St., Franklin
Mrs. Florence Ellen McKee
Greenwood Hilltop Nursing
Home

R. R. 2, Fry Rd., Greenwood
Mr. and Mrs. C. A. Bryant

KNOX COUNTY**Moore's Nursing Home**

204 W. Third St., Bicknell
Mrs. Adeline Bernice Moore

KOSCIUSKO COUNTY**Bradbury Nursing Home**

P. O. Box 15, Atwood
Mrs. Hazel Bradbury
Alfran Nursing Home
R. R. 1, Road #30, Pierceton
Frank N. Wilson and
Alice M. Wilson, R.N.

Armington Home

519 W. Winona Ave., Warsaw
Mrs. Charles Armington

LAGRANGE COUNTY**Blick Convalescent Home**

308-310 S. Detroit St., LaGrange
Mr. and Mrs. J. A. Blick
Maplehaven Rest Home
Mongo
Mrs. Betty L. Bennett

LAKE COUNTY**Hilltop Nursing Home**

R. R. 2, Crown Point
Mrs. Olive Beggs

Shady Heights

Dyer
Mrs. Faye McGuire

Beaton's Nursing Home

521 Pennsylvania St., Gary
Mrs. Laura Beaton

Calloway's Nursing Home

1948 Massachusetts St., Gary
Mrs. Tomye D. Calloway

Green's Home

3960 Massachusetts St., Gary
Mrs. Lillian Green

Miller Nursing Home

2301 Adams St., Gary
Miss Ida Miller

Sanders Nursing Home

1944 Maryland St., Gary
Mrs. LaGora Sanders

**South Side Nursing Home for
The Aged**

2481 Jefferson St., Gary
Mrs. Margaret Morgan

West End Convalescent Home
1501 Wheeler St., Gary
Mrs. Esther G. Jones
Gerrie's Nursing Home
6727 Baring Ave., Hammond
Mrs. Geraldine M. Crawford
Hodge Nursing Home
909 State St., Hammond
Mrs. Lucille Hodge
Lana's Nursing Home
726 Sibley St., Hammond
Mrs. Lana Hodge

LAPORTE COUNTY

White Tower
209 State St., LaPorte
Mrs. Esther Jones
Helene Rest Home
R. R. 3, Johnson Rd., Michigan City
Mrs. Laura R. Prueter

LAWRENCE COUNTY

Kinder Nursing Home
618 "I" St., Bedford
Mrs. Mabel M. Kinder
Maick's Nursing Home
321 "L" St., Bedford
Mrs. Minnie Maick
Norwood Nursing Home
916 14th St., Bedford
Mrs. Estella Norwood
Stancombe Nursing Home
R. R. 5, Bedford
Clifford and Pearl Stancombe
The Greenwell Home
329 W. Oak St., Mitchell
Mrs. Florence Greenwell

MADISON COUNTY

Bradford Nursing Home
625 W. Adams St., Alexandria
Mrs. Alma Bradford
Bright Memorial Home
2025 Jackson St., Anderson
Mrs. Blanche Graser
Goble Home
332 W. 11th St., Anderson
Olive and Oran Goble
McVey Nursing Home
1519 W. 3rd St., Anderson
Mrs. Stella May McVey
Rahbek Nursing Home
711 W. Fifth St., Anderson
Mrs. Marie L. Rahbek
Sanders Nursing Home
1403 Brown St., Anderson
Mrs. Vera M. Sanders
Van Dyke Nursing Home
2417 Pearl St., Anderson
Mrs. Pearl M. Van Dyke
McGuire Nursing Home
2224 S. "K" St., Elwood
Mrs. Nellie Fern McGuire

Scott's Nursing Home
339 Broadway, Pendleton
Mrs. Ruby Scott

MARION COUNTY

Tall Cedars
R. R. 1, Box 27, Bridgeport
Mrs. Ora Miley
Bethel Sanitarium
333 N. Delaware St., Indianapolis
Mrs. Mary E. Rohn
Booker's Convalescent Home
812 E. 14th St., Indianapolis
Mrs. Geneva Booker
Central Nursing Home
2262 Central Ave., Indianapolis
Mrs. Bertha A. Flagle
Christen's Nursing Home
1930 Sugar Grove Ave., Indianapolis
Mrs. Ethel Christen
Conde Nursing Home
624 E. 12th St., Indianapolis
Marian Niles and
Beulah Gronlund
Cottage Rest Home
46 S. Warman Ave., Indianapolis
Mrs. Louise Wooldridge
Elizabeth Nursing Home
2311 N. New Jersey St., Indianapolis
Mrs. Irene Bush
Marie Fred Nursing Home
604 N. Jefferson Ave., Indianapolis
Mrs. Marie Fred, R.N.
Hillside Nursing Home
2370 Hillside Ave., Indianapolis
Mrs. Ella Mason
Hooper Nursing Home
1636-38 N. Illinois St., Indianapolis
Mrs. Carol Hooper
Huff Sanitarium
115 S. Audubon Rd., Indianapolis
Mrs. Rachel A. and
Bettina Sullivan
Irvington Sanitarium
R. R. 10, Box 320, Indianapolis
Mrs. Minnie P. Waymire
Jennings Nursing Home
942 N. Alabama St., Indianapolis
George F. and Clara B. Jennings
King Nursing Home
1907 N. Illinois St., Indianapolis
Mrs. Henrietta Quinn
Myrtle Lee Nursing Home
1429 Carrollton Ave., Indianapolis
Miss Mabel Cecilia Smalley

Lou Wise #2
2516 Central Ave., Indianapolis
Mrs. Bessie Craig
Lucile Nursing Home #2
616 N. Senate Ave., Indianapolis
Mrs. Lucile Mealure
Lynhurst Nursing Home #1
5225 W. Morris St., Indianapolis
Mrs. Mabel Waldkoetter
Martin Nursing Home
1621 Park Ave., Indianapolis
Mrs. Lucille Martin
Martin Nursing Home
2858 N. Illinois St., Indianapolis
Mrs. Beulah Martin
Matthews Rest Home
823 Broadway, Indianapolis
Mrs. Ethel M. Matthews
Messer Nursing Home
2432 Central Ave., Indianapolis
Mary J. and Calvin Messer
Mohler Sanatorium
702-704 N. Alabama St., Indianapolis
John G. Harris
Moye Nursing Home
2115 Central Ave., Indianapolis
Mrs. Agnes Moye
The Murt-McCune Nursing Home
1629 College Ave., Indianapolis
Mrs. Emma Murt and Mrs. Catherine McCune
"Northwestern"
2413 Northwestern Ave., Indianapolis
Mrs. Ray Puryear
Olympia Nursing Home
6759 E. Washington St., Indianapolis
Mrs. Frances Limpus
Pike Sanitarium
2037 N. Illinois St., Indianapolis
Mrs. Lillian G. Pike
Pleasant View Rest Home
5000 Southeastern Ave., Indianapolis
Mrs. Laura E. Weber
Rest Haven Sanitarium
3245 N. Illinois St., Indianapolis
Mrs. Carolyn Carden
Robinson's Private Home #1
2254 Central Ave., Indianapolis
Mrs. Eunice Robinson
Robinson's Private Home #2
2250 Central Ave., Indianapolis
Mrs. Eunice Robinson
Rose Lawn Home
2835 N. Meridian St., Indianapolis
Mrs. Lucy V. Connor

Springer's Nursing Home
6566 W. Washington St., Indianapolis

Millard and Gladys Springer

Suddarth Nursing Home
1445 Broadway, Indianapolis
Mrs. Cleo Suddarth

Sunshine Nursing Home
4416 E. Washington St., Indianapolis

Mrs. Ethel M. Bills

Vollmer Convalescent Home
2630 College Ave., Indianapolis
Mr. Emory H. Vollmer

Mrs. Waddle's Private Home
2112 N. Delaware St., Indianapolis

Mrs. Mable S. Waddle

Ward Nursing Home
1518 N. Senate Ave., Indianapolis

Mrs. Willa Mae Murray

Weber Convalescing Home
43 S. Ritter Ave., Indianapolis
Mrs. Laura E. Weber

West Park Home
373 N. Holmes Ave., Indianapolis
Mrs. Mary R. Frame

MARSHALL COUNTY

Bair Convalescent Home
801 N. Main St., Bourbon
Mrs. Kathryn M. Bair, R.N.

Austin Nursing Home
821 Angell St., Plymouth
Mrs. Mabel M. Austin

Sherman Nursing Home
203 Pennsylvania Ave., Plymouth
Mrs. Vesta K. Sherman

MIAMI COUNTY

Barnes Nursing Home
224 W. 10th St., Peru
Mrs. Charlotte Barnes

The Langer Home
R. R. 4, Peru
Joseph L. and Janet H. Langer, R.N.

Peru Nursing Home
906 W. Main St., Peru

Redmon Nursing Home
225 W. 10th St., Peru
Mrs. Lola Redmon

MONROE COUNTY

Parrott Nursing Home
115 S. Lincoln St., Bloomington
Miss Mary Gwendolia Parrott, R.N.

Percifield Nursing Home
1031 W. 6th St., Bloomington
Mrs. Myrtle D. Percifield

Polley Nursing Home
705 W. 4th St., Bloomington
Mrs. Elsie Mae Polley

Wilkins Nursing Home
1023 E. 10th St., Bloomington
Mrs. Orpha Wilkins

MONTGOMERY COUNTY

Hart Memorial Home
R. R. 1, Crawfordsville
Mrs. Myrtle Johnson

Shahan Nursing Home
613 Kentucky St., Crawfordsville

Miss Eileen M. Shahan
Hazel Small Rest Home
N. Vine St., Waynetown
Mrs. Hazel Small

MORGAN COUNTY

Cherry Nursing Home
R. R. 5, Martinsville
Mrs. Zepha Cherry

NOBLE COUNTY

Golden Rule Nursing Home
R. R. 1, Pierceton
Mr. and Mrs. H. F. Mock

OHIO COUNTY

Galbreath Home
Fourth St., Rising Sun
Mrs. Effie Galbreath

OWEN COUNTY

Gosport Nursing Home
W. Main St., Gosport
Mrs. Mary Wampler
Jones Nursing Home
379 Hillside Ave., Spencer
Mr. and Mrs. Boyd Jones
Reapp Nursing Home
Greencastle Rd., Spencer
Mrs. Jennie C. Reapp

PARKE COUNTY

Wallace Nursing Home
517 W. Ohio St., Rockville
Mrs. Evelyn Wallace

PIKE COUNTY

Fay's Convalescent Home
210 S. 14th St., Petersburg
Mrs. Fay France
Riddle Nursing Home
411 Walnut St., Petersburg
Mrs. Alice M. Riddle

PORTER COUNTY

Wood Home
R. R. 2, West Dunes Highway, Michigan City
Mrs. Helen O. Wood

Beverly Shores Rest Home, Inc.
Beverly Shores
Samuel Robert Barker, M.D.

Wood Nursing Home Annex
R. R. 2, Dunes Highway, Michigan City

Mrs. Helen O. Wood

Valparaiso Nursing Home
359 Greenwich St., Valparaiso
Mr. and Mrs. Orel J. Goble

POSEY COUNTY

Allison Nursing Home
Locust St., Poseyville
Mrs. Lula Allison

PUTNAM COUNTY

Ruark Nursing Home
R. R. 1, Fillmore
Mrs. Elsie Cowgill Ruark

Craver Home

R. R. 3, Greencastle
Mrs. Hannah Craver

Westfall Nursing Home
218 Bloomington St., Greencastle

Mrs. Nina A. Westfall

Milhon Nursing Home
R. R. 1, Fillmore
Mrs. Malissie E. Milhon

Donna Nursing Home
416 E. Hanna St., Greencastle
Mrs. Mildred Brown

RANDOLPH COUNTY

The Ideal Rest Home
104 S. Cherry St., Lynn
Mrs. Blanche E. Allender

Lamb's Nursing Home
R. R. 4, Union City
Mrs. Bernice A. Lamb

Shady Lawn Nursing Home
R. R. 3, Winchester
Mrs. Marjorie Stewart

RIPLEY COUNTY

The Conyer's Nursing Home
Milan
Mrs. Mary Colson

Gilland Nursing Home
310 Craven St., Osgood
Mr. and Mrs. Dan Gilland

Elsie Dreyer Nursing Home
Main St., Sunman
Miss Elsie Dreyer

Mary Dreyer Nursing Home
R. R. 1, Sunman
Mrs. Mary Dreyer

RUSH COUNTY

Clark Nursing Home
230 E. 7th St., Rushville
Mrs. Harry Clark

Clifton Nursing Home #1
204 W. Third St., Rushville
Mrs. Mary Clifton
Clifton Nursing Home #2
R. R. 1, (Circleville), Rushville
Mrs. Mary Clifton
Jackson Nursing Home
114 E. 5th St., Rushville
Mrs. Goldie C. Jackson
Rushville Nursing Home
321 N. Morgan St., Rushville
Mrs. Marjorie Fordyce
Cohee Rest Home
432 W. 1st. St., Rushville
Mrs. Harvey Cohee

SHELBY COUNTY

Maples Convalescent Home
R. R. 1, Fountaintown
Mr. and Mrs. William McGraw
Land's Nursing Home
Morristown
Ida and Elbert Land
Smith Nursing Home
Waldron
Mrs. Avonell Smith

SPENCER COUNTY

Mayhall Nursing Home
417 S. 6th St., Rockport
Mrs. Alice R. Mayhall

ST. JOSEPH COUNTY

Emerick Home
910 W. 4th St., Mishawaka
Mrs. Ila Mae Emerick
Krogh Nursing Home
109 N. Cedar St., Mishawaka
Mrs. Irene K. Simmons
Burbridge Home
1217 S. Michigan St., South Bend
Mrs. Catherine A. Burbridge
Dor-A-Lin Convalescent Home
1024 N. Notre Dame Ave.,
South Bend
Mr. and Mrs. Franklin W.
Finkenbinder
Frame's Nursing Home
1526 Lincoln Way West,
South Bend
Mrs. Myrtle Frame
Grove Nursing Home
601 N. Main St., South Bend
Mrs. Fern Grove
Vera Jones Nursing Home
702 S. Columbia St., South Bend
Mrs. Vera Jones
Morran Nursing Home
2617 S. Main St., South Bend
Helena Elaine Morran
Van Rie Nursing Home
1044 Lincolnway West,
South Bend
Mrs. Frances Van Rie

Whiteman Nursing Home
1145 Napier St., South Bend
Mrs. Betty Whiteman
Mrs. Mary Ellen Farmer, R. N.
Waldron Nursing Home
500 Roosevelt Rd., Walkerton
Mrs. Virginia Waldron

STARKE COUNTY

Ruff Nursing Home
75 W. John St., Knox
Mrs. Alcinda Ruff

STEUBEN COUNTY

Angola Rest Home
306 N. Wayne St., Angola
Mrs. Ruth G. Libby
Edith Nursing Home
116 N. Powers St., Angola
Mrs. Edith Schmidt

TIPPECANOE COUNTY

Laura M. Bowles Convalescent Home
Clarks Hill
Mrs. Laura M. Bowles
Burnett's
221 S. 9th St., Lafayette
Mrs. Maude L. Golden
Cheesman Nursing Home
1021 N. 7th St., Lafayette
Mrs. Addie V. Cheesman
Lewis Nursing Home
641 New York St., Lafayette
Mrs. Betty Mackey Lewis
Scott Nursing Home for Men
614 N. 8th St., Lafayette
Mr. Howard F. Scott
Scott Nursing Home for Women
1100 N. 9th St., Lafayette
Mrs. Goldie Scott

TIPTON COUNTY

Simmons Nursing Home
325 N. West St., Tipton
Mr. and Mrs. Ernest Simmons

UNION COUNTY

Scott Nursing Home
302 W. Union St., Liberty
Mrs. Anna Scott

VANDERBURGH COUNTY

Axton's Rest Home
203 Oakley St., Evansville
Mrs. Maymee M. Axton
Bethany Rest Home
316 N. Wabash Ave., Evansville
Mrs. Edith Poole Masterson
Comfort Rest Home
811 Southeast 3rd St.,
Evansville
Mrs. Viola Barnes

Ditsch Nursing Home
916 W. Michigan St., Evansville
Mrs. Ada Ditsch
E & M Nursing Home
607 E. Walnut St., Evansville
Mrs. Elizabeth Marshall
Evans Nursing Home
605 Oak St., Evansville
Mrs. Anna Evans
Fulton Rest Home
1328 N. Fulton Ave., Evansville
Mrs. Grace L. Richter
Gee's Rest Haven
807 Southeast 3rd St.,
Evansville
Mrs. Leona Gee
Jarrett Convalescent Home
605 Oakley St., Evansville
Mrs. Lena K. Jarrett
M & R Nursing Home
1100 N. Read St., Evansville
Mrs. Muriel B. Sprinkle
Maxey Nursing Home
909 First Ave., Evansville
Mr. and Mrs. Pearlless Maxey
The Newton Rest Home
923 S. Elliott St., Evansville
Mrs. Gwendolyn Newton
Pleasant Nursing Home
109 W. Maryland St., Evansville
Mrs. Maryetta Morris
Ingle Smith Home
521 S. E. First St., Evansville
Mrs. Della Ingle Smith, R.N.
Stinson Rest Home
315 Southeast Second St.,
Evansville
Mrs. Mildred Stinson
Taylor Nursing Home
915 W. Bond St., Evansville
Mrs. Juanita Taylor
Tindall Rest Home
218 Harriett St., Evansville
Mrs. Gwendolyn Newton
Ulbricht Rest Home
616 W. Franklin St., Evansville
Mrs. Martha Ulbricht

VIGO COUNTY

Calvary Nursing Home
421 N. Fifth St., Terre Haute
Mrs. Oakie Lawson
Cook Nursing Home
2058 N. 7th St., Terre Haute
Mrs. Grace E. Cook
Foos Nursing Home
418 S. 8th St., Terre Haute
Mrs. Lydia E. Foos
Gano Nursing Home
501 N. 4th St., Terre Haute
Mrs. Anna Gano

Hise Nursing Home
120 N. 12th St., Terre Haute
Mrs. Lillie Hise

Kesler's Nursing Home
724 N. 8th St., Terre Haute
Mrs. Clara A. Kesler

Mary Etta Nursing Home
241 N. 13th St., Terre Haute
Mrs. Mamie Mason

Mrs. Barney Pigg Nursing Home

1334 Sycamore St.
Terre Haute

Mrs. Barney Pigg
Sharps Nursing Home

1518 N. Center, Terre Haute
Mrs. Hazel M. Sharps

Smith Nursing Home
202 N. 23rd St., Terre Haute
Mrs. Edith C. Smith

Sullivan Nursing Home
705 S. 7th St., Terre Haute

Mrs. Grace F. Sullivan
Trainer Nursing Home

1915 N. 11th St., Terre Haute
Mrs. Geneva Trainer

WABASH COUNTY

The Pilgrim Nursing Home
306 E. 4th St., North Manchester

Mrs. Pearl Lambert
Dunfee Nursing Home
1250 Pike St., Wabash
Mrs. Florence Dunfee

Moss Nursing Home
855 Ferry St., Wabash
Mrs. Irene Moss

WARREN COUNTY

The Ellen Home
20 Falls St., Williamsport

WARRICK COUNTY

Hollis Nursing Home
R. R. 5, Boonville
Mrs. Loraine Hollis

Hollis Nursing Home #2
R. R. 5, Boonville
Mrs. Loraine Hollis

WASHINGTON COUNTY

Shuell Nursing Home #1
R. R. 1, Scottsburg
Mrs. Ella L. Shuell, R.N.

WAYNE COUNTY

Bowman's Rest Home
444 W. Main St., Cambridge City
Esther Bowman

Pinehurst Nursing Home
R. R. 1, Centerville
Mrs. Gertrude E. Johnson

Twin Pines Nursing Home
Main St., Economy
Marguerite C. Potts

Reynolds Convalescent Home
R. R. 2, Hagerstown
Mrs. Adeline Reynolds

Gains Nursing Home #1
R. R. 2, Box 448, Richmond
Mrs. Emma Gains

Gains Nursing Home #2
R. R. 2, Box 448, Richmond
Mrs. Emma Gains

Gains Nursing Home No. 3
R. R. 2, Box 448, Richmond
Mrs. Emma Gains

Jennie Hartman Nursing Home
139 S. E. 14th St., Richmond
Mrs. Jennie Hartman

WELLS COUNTY

Davis Nursing Home
R. R. 3, Bluffton
Mrs. I. Helen Davis

Clark's Nursing Home
522 E. South St., Bluffton
Mrs. Clara Clark

WHITLEY COUNTY

Farris Nursing Home
209 W. Market St.,
Columbia City
Mrs. Louise Farris

Irvin Nursing Home
604 W. Van Buren St.,
Columbia City

Mrs. Marguerite Irvin

South Whitley Rest Home, Inc.
306 Columbia St., South Whitley
Robert E. Bresnahan and Katherine A. Bresnahan, R.N.



LICENSED PRIVATE MENTAL INSTITUTIONS IN INDIANA

Mt. Mercy Sanitarium
1628 Ridge Road
Hammond, Indiana

Norways Foundation Hospital
1800 East 10th Street
Indianapolis

Clearview
P.O. Box 837, Kratzville Road
Evansville

The Retreat (Alcoholic)
41 West 32nd Street
Indianapolis

Wabash Valley Sanitarium
Lafayette
(temporary license)

Indiana Home, Inc.
1341 North Alabama Street
Indianapolis

PRESIDENTS OF THE INDIANA STATE MEDICAL ASSOCIATION SINCE ITS ORGANIZATION

Name and Residence	Elected	Served	Name and Residence	Elected	Served
Medical Convention			*James H. Ford, Wabash-----	1896	1897
*Livingston Dunlap, Indianapolis----	1849	1849	*William N. Wishard, Indianapolis----	1897	1898
Medical Society			*John C. Sexton, Rushville-----	1898	1899
*William T. S. Cornett, Versailles----	1849	1850	*Walker Schell, Terre Haute-----	1899	1900
*Ashahel Clapp, New Albany-----	1850	1851	*George W. McCaskey, Ft. Wayne----	1900	1901
*George W. Mears, Indianapolis-----	1851	1852	*Alembert W. Brayton, Indianapolis--	1901	1902
*Jeremiah H. Brower, Lawrenceburg--	1852	1853	*John B. Berteling, South Bend-----	1902	1903
*Elizur H. Deming, Lafayette-----	1853	1854	Medical Association		
*Madison J. Bray, Evansville-----	1854	1855	*Jonas Stewart, Anderson-----	1903	1904
*William Lomax, Marion-----	1855	1856	*George T. MacCoy, Columbus-----	1904	1905
*Daniel Meeker, LaPorte-----	1856	1857	*George H. Grant, Richmond-----	1905	1906
*Talbot Bullard, Indianapolis-----	1857	1858	*George J. Cook, Indianapolis-----	1906	1907
*Nathan Johnson, Cambridge City----	1858	1859	*David C. Peyton, Jeffersonville-----	1907	1908
*David Hutchinson, Mooresville-----	1859	1860	*George D. Kahlo, French Lick-----	1908	1909
*Benjamin S. Woodworth, Ft. Wayne	1860	1861	*Thomas C. Kennedy, Shelbyville-----	1909	1910
*Theophilus Parvin, Indianapolis----	1861	1862	*Frederick C. Heath, Indianapolis----	1910	1911
*James F. Hibberd, Richmond-----	1862	1863	*William F. Howat, Hammond-----	1911	1912
*John Sloan, New Albany-----	1863	----	*A. C. Kimberlin, Indianapolis-----	1912	1913
*John Moffett (acting), Rushville----	1863	1864	*John P. Salb, Jasper-----	1913	1914
*Samuel L. Linton, Columbus-----	1864	----	*Frank B. Wynn, Indianapolis-----	1914	1915
*William Lockhart (acting), Danville--	1864	1865	*George F. Keiper, Lafayette-----	1915	1916
*Myron H. Harding, Lawrenceburg--	1865	1866	*John H. Oliver, Indianapolis-----	1916	1917
*Vierling Kersey, Richmond-----	1866	1867	*Joseph Rilus Eastman, Indianapolis--	1917	1918
*John S. Bobbs, Indianapolis-----	1867	1868	William H. Stemm, North Vernon----	1918	1919
*Nathaniel Field, Jeffersonville-----	1868	1869	*Charles H. McCully, Logansport-----	1919	1920
*George Sutton, Aurora-----	1869	1870	*David Ross, Indianapolis-----	1920	1921
*Robert N. Todd, Indianapolis-----	1870	1871	*William R. Davidson, Evansville----	1921	1922
*Henry P. Ayres, Ft. Wayne-----	1871	1872	*Charles H. Good, Huntington-----	1922	1923
*Joel Pennington, Milton-----	1872	1873	*Samuel E. Earp, Indianapolis-----	1923	1924
*Isaac Casselberry, Evansville-----	1873	----	Eldridge M. Shanklin, Hammond-----	1924	1925
*Wilson Hobbs (acting), Knights-			Charles N. Combs, Terre Haute-----	1925	1926
town -----	1873	1874	*Frank W. Cregor, Indianapolis-----	1926	1927
*Richard E. Houghton, Richmond----	1874	1875	George R. Daniels, Marion-----	1926	1928
*John H. Helm, Peru-----	1875	1876	Charles E. Gillespie, Seymour-----	1927	1929
*Samuel S. Boyd, Dublin-----	1876	1877	*Angus C. McDonald, Warsaw-----	1928	1930
*Luther D. Waterman, Indianapolis--	1877	1878	*Alois B. Graham, Indianapolis-----	1929	1931
*Louis Humphreys, South Bend-----	1878	----	Franklin S. Crockett, Lafayette-----	1930	1932
*Benj. Newland (acting), Bedford			Joseph H. Weinstein, Terre Haute--	1931	1933
(v.p.) -----	1878	1879	*Everett E. Padgett, Indianapolis----	1932	1934
*Jacob R. Weist, Richmond-----	1879	1880	*Walter J. Leach, New Albany-----	1933	1935
*Thomas B. Harvey, Indianapolis----	1880	1881	Roscoe L. Sensenich, South Bend...	1934	1936
*Marshall Sexton, Rushville-----	1881	1882	*Edmund D. Clark, Indianapolis-----	1935	1937
*William H. Bell, Logansport-----	1882	1883	Herman M. Baker, Evansville-----	1936	1938
*Samuel E. Mumford, Princeton-----	1883	1884	*Edmund M. Van Buskirk, Ft. Wayne--	1937	1939
*James H. Woodburn, Indianapolis----	1884	1885	Karl R. Ruddell, Indianapolis-----	1938	1940
*James S. Gregg, Ft. Wayne-----	1885	1886	*Albert M. Mitchell, Terre Haute----	1939	1941
*General W. H. Kemper, Muncie-----	1886	1887	Maynard A. Austin, Anderson-----	1940	1942
*Samuel H. Charlton, Seymour-----	1887	1888	Carl H. McCaskey, Indianapolis-----	1941	1943
*William H. Wishard, Indianapolis----	1888	1889	Jacob T. Oliphant, Farmersburg-----	1942	1944
*James D. Gatch, Lawrenceburg-----	1889	1890	Neslen K. Forster, Hammond-----	1943	1945
*Gonsolvo C. Smythe, Greencastle----	1890	1891	*Jesse E. Ferrell, Fortville-----	1944	1946
*Edwin Walker, Evansville-----	1891	1892	Floyd T. Romberger, Lafayette-----	1945	1947
*George F. Beasley, Lafayette-----	1892	1893	Cleon A. Nafe, Indianapolis-----	1946	1948
*Charles A. Daugherty, South Bend..	1893	1894	Augustus P. Hauss, New Albany-----	1947	1949
*Elijah S. Elder, Indianapolis-----	1894	----	C. S. Black, Warren-----	1948	1950
Charles S. Bond (acting), Richmond	1894	1895	Alfred Ellison, South Bend-----	1949	1951
*Miles F. Porter, Ft. Wayne-----	1895	1896	J. William Wright, Indianapolis-----	1950	1952
			Paul D. Crimm, Evansville-----	1951	1953

* Deceased.

Membership Roster

INDIANA STATE MEDICAL ASSOCIATION

Following is a list of members of the Indiana State Medical Association as of December 31, 1952, plus those who have become members between December 31, 1952 and June 1, 1953.

The letter (S) following a name indicates that the physician is a senior member of his local society and of the Indiana State Medical Association. The letter (H) following a name indicates that the physician is an honorary member of his local society and the Indiana State Medical Association.

Names of members who have died during the year do not appear in this list.

If any errors are found in this list, please report them to THE JOURNAL, 1017 Hume Mansur Building, Indianapolis 4, Indiana. The cooperation of members is urgently requested.

ALPHABETICAL LIST OF MEMBERS

A

Name	City	County	Name	City	County
Aagesen, J. W.	Anderson	Madison	Allen, Orris T.	Terre Haute	Vigo
Abel, J. A.	South Bend	St. Joseph	Allen, Robert K.	Indianapolis	Marion
Abel, Robert	Wakarusa	Elkhart	Allen, Robert T.	Richmond	Wayne-Union
Abell, Charles F.	Marion	Grant	Almquist, C. O.	Gary	Lake
Abreu, Benedict E.	Indianapolis	Marion	Altier, W. H.	Fowler	Benton
Acher, Robert P.	Greensburg	Decatur	Alvey, Charles R.	Muncie	Delaware-
Acker, Robert B.	South Bend	St. Joseph			Blackford
Acos, James C.	East Chicago	Lake	Alvis, Edmond O.	Indianapolis	Marion
Acre, R. R.	Evansville	Vanderburgh	Alward, John Haney	Kokomo	Howard
Adair, Fred L. (H)	Maitland, Fla.	Porter	Amberg, Edward A.	Hammond	Lake
Adair, Samuel L.	Jeffersonville	Clark	Ambrose, J. C.	Noblesville	Hamilton
Adair, Wm. K.	Crothersville	Jackson	Ames, George F. (S)	Eaton	Delaware-
Adams, Charles J.	Kokomo	Howard			Blackford
Adams, Max R.	Flora	Carroll	Amick, Charles L.	Wakarusa	Elkhart
Adams, William B.	Muncie	Delaware-	Amini, Sohrab	Huntingburg	Dubois
		Blackford	Amos, R. L.	New Castle	Henry
Adamski, Michael S.	Logansport	Cass	Amstutz, Henry C.	Goshen	Elkhart
Ade, C. H.	Lafayette	Tippecanoe	Amy, W. E.	Corydon	Harrison-
Ade, Mary	Lafayette	Tippecanoe			Crawford
Adkins, H. C.	Indianapolis	Marion	Anderson, Dwight	Evansville	Vanderburgh
Adkins, Onan C.	Indianapolis	Marion	Anderson, John T.	Indianapolis	Marion
Adler, David L.	Columbus	Bartholomew-	Anderson, R. M.	Vincennes	Knox
		Brown	Anderson, Walter C.	Terre Haute	Vigo
Adler, Edmund R.	Dyer	Lake	Anderson, Wendell C.	Indianapolis	Marion
Adler, Raymond N.	Evansville	Vanderburgh	Annis, Homer B.	Bluffton	Wells
Adney, Frank B., Jr.	Richmond	Wayne-Union	Antes, Earl H.	Evansville	Vanderburgh
Agee, Ernest B., Jr.	Terre Haute	Vigo	Appel, Richard H.	Indianapolis	Marion
Aiken, Arthur F.	Ft. Wayne	Allen	Apple, Eddie R.	Salem	Washington
Aiken, Milo M.	Plainfield	Hendricks	Applegate, Albert E.	Frankfort	Clinton
Aiken, N. E.	Ft. Wayne	Allen	Arata, Justin E.	Fort Wayne	Allen
Ake, Loren	Richmond	Wayne-Union	Arbeiter, Herbert I.	Hammond	Lake
Albertson, F. P.	Indianapolis	Marion	Arbogast, J. L.	Indianapolis	Marion
Alcorn, Merritt O.	Madison	Jefferson-	Arbogast, Paul B.	Vincennes	Knox
		Switzerland	Arbonies, William G.	Terre Haute	Vigo
Alderfer, Henry	Marion	Grant	Arbuckle, Russell L.	Indianapolis	Marion
Aldrich, Harry	Indianapolis	Marion	Arbuckle, Wm. E.	Indianapolis	Marion
Aldrich, Howard	Indianapolis	Marion	Arisman, R. K.	South Bend	St. Joseph
Alexander, Ezra D.	Indianapolis	Marion	Arlook, Theodore D.	Elkhart	Elkhart
Alexander, H. H.	Princeton	Gibson	Armalavage, Leon T.	Gary	Lake
Alexander, J. E.	Evansville	Vanderburgh	Armington, C. L.	Anderson	Madison
Alexander, O. O.	Terre Haute	Vigo	Armington, John C. (S)	Anderson	Madison
Alexander, P. M.	Martinsville	Morgan	Armington, Robert	Anderson	Madison
Alexander, Stephen J.	Crawfordsville	Montgomery	Armstrong, T. D.	Michigan City	La Porte
Alford, James	Hamilton	Steuben	Arnett, A. C.	Lafayette	Tippecanoe
Allegretti, Michael	Hammond	Lake	Arnold, Aaron L.	Indianapolis	Marion
Allen, Fred K.	New Albany	Floyd	Arnold, M. F.	East Chicago	Lake
Allen, Hubert E.	Richmond	Wayne-Union	Arnold, Robert D.	Indianapolis	Marion
Allen, J. L. (S)	Greenfield	Hancock	Aronson, Sidney S.	Indianapolis	Marion
Allen, L. Howard	Bedford	Lawrence	Arrowsmith, James L.	Hammond	Lake

Name	City	County	Name	City	County
Arthur, H. M. (S)	Hazleton	Gibson	Barnum, Emerson	Shelbyville	Shelby
Arthur, Nora M.	Washington	Daviess-Martin	Barone, Carmelo V.	Mishawaka	St. Joseph
Asbury, W. D. (S)	Terre Haute	Vigo	Barron, Elmer A.	East Chicago	Lake
Ash, H. H.	W. Lafayette	Tippecanoe	Barrow, John H.	Dale	Spencer
Ashcraft, John R.	Anderson	Madison	Barry, M. J.	Indianapolis	Marion
Asher, E. O.	New Augusta	Marion	Bartholomew, Mary	Goshen	Elkhart
Asher, James W.	New Augusta	Marion	Bartle, J. Leo	Indianapolis	Marion
Ashmore, Herbert C.	Hebron	Porter	Bartley, Max D.	Indianapolis	Marion
Atchison, Kenneth C.	Rockport	Spencer	Barton, Robert	Angola	Steuben
Atkins, C. C.	Rushville	Rush	Barton, W. M.	Centerville	Wayne-Union
Atkinson, C. W. (S)	Boswell	Benton	Bartsch, Harvey L.	South Bend	St. Joseph
Aucremen, C. J.	Bluffton	Wells	Bash, Wallace E.	Fort Wayne	Allen
Ault, Carl H.	Kokomo	Howard	Baskett, R. J.	Jonesboro	Grant
Ault, Roy, Jr.	Terre Haute	Vigo	Bassett, Clancy	Thorntown	Boone
Austin, Charles E.	Anderson	Madison	Bassett, Margaret	Thorntown	Boone
Austin, Eugene W.	Evansville	Vanderburgh	Bassler, C. R.	Mishawaka	St. Joseph
Austin, F. H. (S)	Bloomington	Owen-Monroe	Bates, George	Marion	Grant
Austin, M. A. (S)	Anderson	Madison	Batman, Gordon W.	Indianapolis	Marion
Austin, R. P.	Bedford	Lawrence	Battersby, J. Stanley	Indianapolis	Marion
Avery, George	Indianapolis	Marion	Batties, Paul A.	Indianapolis	Marion
Ayres, Kenneth D.	Anderson	Madison	Bauer, A. J.	Lafayette	Tippecanoe
Ayres, W. W.	Marion	Grant	Bauer, Thomas B.	Indianapolis	Marion
B			Baughn, William L.	Anderson	Madison
Babb, Forrest J.	Stockwell	Tippecanoe	Baum, Harry	Indianapolis	Marion
Bachmann, Arnold J.	Indianapolis	Marion	Baumeister, Herbert E.	Indianapolis	Marion
Backer, Henry G.	Ferdinand	Dubois	Baumgartner, Jeraldine	Fort Wayne	Allen
Badders, A. C.	Portland	Jay	Baxter, J. W., Jr.	New Albany	Floyd
Bailey, Edwin B.	Linton	Greene	Baxter, Neal	Bloomington	Owen-Monroe
Bailey, E. W.	Logansport	Cass	Baxter, Samuel M.	New Albany	Floyd
Bailey, L. S.	Zionsville	Boone	Bayley, William E.	Lafayette	Tippecanoe
Bailey, Orville T.	Indianapolis	Marion	Baylor, Edward M.	Evansville	Vanderburgh
Bailey, Paul P.	Fort Wayne	Allen	Baynes, Frank L.	Wolcott	White
Bailey, Wm. A. (S)	Vincennes	Knox	Beach, Robert R.	Indianapolis	Marion
Baitinger, H. M.	Gary	Lake	Beam, Vernon B.	East Chicago	Lake
Bakemeier, O. H.	Indianapolis	Marion	Beams, Ralph H.	Fort Wayne	Allen
Baker, A. M.	New Albany	Floyd	Bean, Joseph S.	Indianapolis	Marion
Baker, G. D.	Crandall	Harrison-Crawford	Bear, L. H. (S)	Indianapolis	Jefferson-Switzerland
Baker, Herman	Evansville	Vanderburgh	Beardsley, Frank A.	Frankfort	Clinton
Baker, J. S. (S)	Evansville	Vanderburgh	Beardsley, John	Frankfort	Clinton
Baker, Leslie M.	Aurora	Dearborn-Ohio	Beasley, T. J.	Indianapolis	Marion
Baker, Mason R.	Evansville	Vanderburgh	Beaver, Ernest R.	Rensselaer	Jasper-Newton
Baker, Milan D.	Culver	Marshall	Beaver, Howard W.	Indianapolis	Marion
Baker, Robert E. (S)	Orleans	Orange	Beaver, Norman	Berne	Adams
Baker, Warren	Michigan City	LaPorte	Bechtol, Lavon D.	Morton Grove, Ill.	Lake
Balch, James F.	Indianapolis	Marion	Bechtold, S. E.	South Bend	St. Joseph
Baldrige, W. O.	Terre Haute	Vigo	Beck, David C.	Monticello	White
Baldwin, J. H. (S)	Jeffersonville	Clark	Beck, Evert M.	Indianapolis	Marion
Balkema, Cath. M.	Lafayette	Tippecanoe	Beck, H. A.	Lebanon	Boone
Ball, Clay A.	Muncie	Delaware-Blackford	Beck, Robert E.	Evansville	Vanderburgh
Ball, John R.	Indianapolis	Marion	Becker, Harry G.	Indianapolis	Marion
Ball, Joseph E.	Indianapolis	Marion	Becker, Philip H.	Crown Point	Lake
Ball, Phillip	Muncie	Delaware-Blackford	Beckes, E. W.	Vincennes	Knox
Ball, T. Z. (S)	Crawfordsville	Montgomery	Beckman, H. F. (S)	Indianapolis	Marion
Balla, Morris	South Bend	St. Joseph	Beconovich, Robert	Hammond	Lake
Ballard, C. A.	Logansport	Cass	Bedwell, Marion H.	Sullivan	Sullivan
Ballas, William A.	Evansville	Vanderburgh	Beeler, J. Moss	Lafayette	Tippecanoe
Ballenger, W. E.	Richmond	Wayne-Union	Beeler, John W.	Indianapolis	Marion
Balsbaugh, George	N. Manchester	Wabash	Beeler, Raymond C.	Indianapolis	Marion
Baltes, Joseph H.	Fort Wayne	Allen	Beeson, Wilbur	Greenfield	Hancock
Banister, R. F.	Indianapolis	Marion	Beetem, L. F.	Madison	Jefferson-Switzerland
Bankoff, Milton L.	Michigan City	LaPorte	Begley, Joseph W., Jr.	Evansville	Vanderburgh
Banks, H. M.	Indianapolis	Marion	Beggs, L. F.	Columbus	Bartholomew-Brown
Bannon, William G.	Terre Haute	Vigo	Behn, Walter M.	Gary	Lake
Baran, Charles	South Bend	St. Joseph	Behnke, Roy H.	Indianapolis	Marion
Barclay, I. C.	Evansville	Vanderburgh	Beierlein, Karl	Fort Wayne	Allen
Bard, Frank B.	Crothersville	Jackson	Beilke, Clifford A.	East Chicago	Lake
Barnes, Helen B.	Greenwood	Johnson	Belshaw, George	Terre Haute	Vigo
Barnett, R. E.	Peru	Miami	Benchik, Frank A.	East Chicago	Lake
Barnhart, Willard T.	Evansville	Vanderburgh			

Name	City	County	Name	City	County
Bender, Cecil K.	Goshen	Elkhart	Bloom, Asa Ward	Marion	Grant
Bender, Robert L.	Elkhart	Elkhart	Bloom, George R.	Elkhart	Elkhart
Bendler, Carl H.	Gary	Lake	Bloomer, J. R.	Rockville	Parke- Vermillion
Benedek, Tibor	East Chicago	Lake	Bloomer, R. S.	Rockville	Parke- Vermillion
Benedict, Charles D.	LaGrange	LaGrange	Blosser, B. A.	Fremont	Steuben
Benham, L. E.	Bedford	Lawrence	Blosser, H. V. (S)	Fort Wayne	Allen
Bennett, Abner P.	Evansville	Vanderburgh	Blossom, Paul W.	Richmond	Wayne- Union
Bennett, J. B.	Warren	Huntington	Blum, Leon L.	Terre Haute	Vigo
Bennett, Jene R.	South Bend	St. Joseph	Boardman, Carl	Gary	Lake
Benning, Chas., H.P.G.	Wilmingon, Del.	Lake	Boaz, John J. (S)	Indianapolis	Marion
Benninghoff, D. R.	Fort Wayne	Allen	Bobb, Kenneth E.	Indianapolis	Marion
Benoit, Merrill T.	Anderson	Madison	Bock, Don G.	Battle Creek, Mich.	Marion
Benz, Jesse	Marengo	Harrison- Crawford	Bodnar, Leslie M.	South Bend	St. Joseph
Benz, O. F.	Wanatah	LaPorte	Bogardus, C. R.	Austin	Scott
Bergan, Joseph A.	McKinney, Tex.	Lake	Boggs, E. F.	Indianapolis	Marion
Bergendahl, Emil H.	Fort Wayne	Allen	Bohner, C. B.	Indianapolis	Marion
Berger, Henry I.	Indianapolis	Marion	Bolin, John T.	Cedar Lake	Lake
Berger, Morley	Beech Grove	Marion	Bolin, Robert S.	Elkhart	Elkhart
Berghoff, Raymond	Fort Wayne	Allen	Boling, Grover C., Jr.	Indianapolis	Marion
Bergenwall, Warren L.	Indianapolis	Marion	Bolka, B. J.	South Bend	St. Joseph
Berke, Robert	South Bend	St. Joseph	Bolman, Ralph M.	Fort Wayne	Allen
Berkebile, J. B.	Peru	Miami	Bonaventura, A. P.	East Chicago	Lake
Berman, Edward J.	Indianapolis	Marion	Bond, Charles S. (S)	Richmond	Wayne- Union
Berman, Jacob K.	Indianapolis	Marion	Bond, George S.	Indianapolis	Marion
Bernardi, Hugh	East Chicago	Lake	Bond, Virginia	Indianapolis	Marion
Bernoske, D. G.	Michigan City	LaPorte	Bond, Walter	Clay City	Clay
Best, Robert C.	Whiting	Lake	Bond, William H.	Indianapolis	Marion
Bethea, Robert O.	Farmersburg	Sullivan	Bonner, Joseph N.	Fort Wayne	Allen
Berton, William M.	Durham, N.C.	Marion	Bonsett, Charles A.	Indianapolis	Marion
Beverland, M. E.	Indianapolis	Marion	Booher, Norman R.	Indianapolis	Marion
Biasini, Benedict A.	South Bend	St. Joseph	Booher, Olga	Indianapolis	Marion
Bibler, Henry E.	Muncie	Delaware- Blackford	Booth, Boynton H.	Indianapolis	Marion
Bibler, L. D.	Indianapolis	Marion	Bopp, Henry, Jr.	Terre Haute	Vigo
Bichacoff, Billie D.	Fort Wayne	Allen	Bopp, Henry W.	Terre Haute	Vigo
Bickel, David A.	South Bend	St. Joseph	Bopp, James	Terre Haute	Vigo
Bickel, J. E. (S)	Fort Wayne	Allen	Borak, Walter J.	Gary	Lake
Bidney, Evelyn B.	Bloomington	Owen-Monroe	Borders, Theo. R.	Fort Wayne	Allen
Bigler, Frederick	Goshen	Elkhart	Boren, Paul	Poseyville	Posey
Billings, Elmer R.	Elkhart	Elkhart	Boren, Samuel W. (S)	Poseyville	Posey
Billman, Gustus S.	Shelbyville	Shelby	Borland, R. M.	Bloomington	Owen- Monroe
Bills, L. F.	Culver	Marshall	Borough, L. D	South Bend	St. Joseph
Bills, R. N.	Gary	Lake	Bosenbury, Charles S. (S)	South Bend	St. Joseph
Bird, Chas. R. (S)	Indianapolis	Marion	Bosler, Howard A.	Waterford Mills	Elkhart
Birdzell, John P.	Crown Point	Lake		Mail Goshen	
Birmingham, P. J.	South Bend	St. Joseph	Boswell, Robert W.	Evansville	Vanderburgh
Bishop, Charles A.	South Bend	St. Joseph	Bothwell, C. G.	Martinsville	Morgan
Bishop, Harry A.	Frankton	Madison	Botkin, Clyde G.	Muncie	Delaware- Blackford
Bissonnette, Roger P.	Evansville	Vanderburgh	Botkin, Thomas	Muncie	Delaware- Blackford
Bitler, C. C.	New Castle	Henry	Bottorff, David C.	Charlestown	Clark
Bivin, James H.	Indianapolis	Marion	Boughman, Joseph D.	Kokomo	Howard
Bixler, Donald P.	Anderson	Madison	Bowdoin, G. E.	Elkhart	Elkhart
Bixler, Louis C.	South Bend	St. Joseph	Bowen, Otis R.	Bremen	Marshall
Bizer, Mier A.	Cincinnati, O.	Clark	Bowers, Copeland C.	Kokomo	Howard
Bjorklund, C. Ray	Hobart	Lake	Bowers, Don D.	Indianapolis	Marion
Black, C. S.	Warren	Huntington	Bowers, G. T.	Fort Wayne	Allen
Black, Charles E.	Hammond	Lake	Bowers, Garvey B.	Kokomo	Howard
Black, Edgar K.	Wabash	Wabash	Bowers, John A.	Kokomo	Howard
Black, Joe M.	Seymour	Jackson	Bowers, J. W.	Fort Wayne	Allen
Blackburn, Erwin	South Bend	St. Joseph	Bowman, Charles M.	Albion	Noble
Blackford, Milforde	Indianapolis	Marion	Bowman, George W.	Indianapolis	Marion
Blassaras, Chris	Anderson	Madison	Bowman, Harold E.	Detroit, Mich.	Marion
Blatt, A. E.	Indianapolis	Marion	Bowman, Ralph	Marshall	Parke- Vermillion
Blazey, A. G.	Washington	Daviess- Martin	Boyd, C. L. (S)	Vincennes	Knox
Bledsoe, James G.	New Castle	Henry	Boyd, Charles S.	East Chicago	Lake
Blemker, Russell M.	Greensburg	Decatur	Boyd, Clarence E.	West Baden	Orange
Blessinger, Louis Henry	Corydon	Harrison- Crawford			
Blessinger, Paul J.	Jasper	Dubois			
Blix, Fred M.	Ladoga	Montgomery			
Bloemker, E. F.	Indianapolis	Marion			

Name	City	County	Name	City	County
Boyd, Stella N.	Evansville	Vanderburgh	Bruetsch, Walter L.	Indianapolis	Marion
Boyer, E. B.	Indianapolis	Marion	Bruggeman, H. O.	Ft. Wayne	Allen
Boyer, Floyd A.	Indianapolis	Marion	Bruner, Ralph	Jeffersonville	Clark
Boyer, Grace B.	Marion	Grant	Brunoehler, Carl J.	Muncie	Delaware- Blackford
Boys, F. F.	East Chicago	Lake			
Bradley, Stephen C.	Terre Haute	Vigo	Bryan, F. A.	Ft. Wayne	Allen
Brady, Samuel	Gary	Lake	Bryan, Robert E.	Kendallville	Noble
Brady, Thomas A.	Indianapolis	Marion	Bryan, Robert J.	South Bend	St. Joseph
Brandman, Harry	Gary	Lake	Bryan, S. L.	Evansville	Vanderburgh
Brauchla, C. H.	Anderson	Madison	Buchanan, W. D.	South Bend	St. Joseph
Brauer, Abraham A.	East Chicago	Lake	Buche, F. P.	Richmond	Wayne- Union
Braun, Benjamin D.	Chicago, Ill.	Lake			
Braunlin, Robert F.	Marion	Grant	Buchholz, Ransom R.	Evansville	Vanderburgh
Braunlin, W. H.	Marion	Grant	Buck, Charles E.	Indianapolis	Marion
Brayton, John R.	Indianapolis	Marion	Buckingham, Richard	Bloomington	Owen- Monroe
Brayton, Lee	Indianapolis	Marion			
Brechtol, Harvey J.	South Bend	St. Joseph	Buckles, David L.	Anderson	Madison
Brenner, I. E.	Winchester	Randolph	Buckley, E. P.	Jeffersonville	Clark
Bretz, John M.	Huntingburg	Dubois	Buckner, Doster	Ft. Wayne	Allen
Bretz, W. D.	Huntingburg	Dubois	Buckner, George D.	Fort Wayne	Allen
Brickley, H. D.	Bluffton	Wells	Buckner, Joy F.	Bluffton	Wells
Brickley, Richard A.	Bluffton	Wells	Buehler, George M.	Jeffersonville	Clark
Bridges, William L.	Indianapolis	Marion	Buechner, F. W.	South Bend	St. Joseph
Bridwell, Edgar	Bedford	Lawrence	Buehner, Donald F.	Evansville	Vanderburgh
Briggs, Robert W.	Indianapolis	Marion	Buhrmester, H. C.	Lafayette	Tippecanoe
Brink, Calvin C.	Gary	Lake	Buikstra, C. R.	Evansville	Vanderburgh
Brincko, John	Indianapolis	Marion	Bullard, Mattie J.	Gary	Lake
Briscoe, C. E. (S)	New Albany	Floyd	Bulson, Eugene L.	Ft. Wayne	Allen
Britton, W. D.	Montezuma	Parke- Vermillion	Bunde, Carl	Indianapolis	Marion
			Bunker, L. Z.	N. Manchester	Wabash
Brock, Earl E.	Anderson	Madison	Burcham, J. B.	Gary	Lake
Brockman, Wilfred	Corydon	Harrison- Crawford	Burdette, Harold r.	Indianapolis	Marion
			Burge, A. D. (S)	Marion	Grant
Brockmeier, Frederick	Indianapolis	Marion	Burghard, D. Rolla	Indianapolis	Marion
Brockmole, Arnold W.	Evansville	Vanderburgh	Burk, James M.	Decatur	Adams
Brodie, Donald W.	Indianapolis	Marion	Burket, Cecil R.	Norfolk, Va.	St. Joseph
Bronson, Paul J.	Terre Haute	Vigo	Burkhardt, B. A.	Tipton	Tipton
Brooks, H. L.	Michigan City	LaPorte	Burkle, J. C.	Lafayette	Tippecanoe
Broomes, Edward L. C.	East Chicago	Lake	Burks, Jess E.	Crawfordsville	Montgomery
Broshears, Kenneth	Linton	Greene	Burman, Richard G.	Jeffersonville	Clark
Brosius, Robert H. W.	Ft. Wayne	Allen	Burnett, Arthur B.	New Castle	Henry
Brown, A. E.	Indianapolis	Marion			
Brown, D. B.	Gary	Lake	Burney, Leroy E.	Indianapolis	Marion
Brown, David E.	Indianapolis	Marion	Burnikel, Ray H.	Evansville	Vanderburgh
Brown, Dewitt W.	Indianapolis	Marion	Burns, Paul E.	Montpelier	Delaware- Blackford
Brown, Edward A. (S)	Indianapolis	Marion			
Brown, Frances T.	Indianapolis	Marion	Burress, B. O. (S)	Washington	Daviess- Martin
Brown, Frederick R.	Ellettsville	Owen-Monroe			
Brown, Frederic W.	Ft. Wayne	Allen	Burris, F. L.	Michigan City	LaPorte
Brown, George E.	Greenwood	Johnson	Burroughs, C. A.	Frankfort	Clinton
Brown, James A., Sr.	Evansville	Vanderburgh	Burrous, E. Lee	Peru	Miami
Brown, James C.	Valparaiso	Porter	Burwell, Stanley W.	Muncie	Delaware- Blackford
Brown, James M.	Anderson	Madison			
Brown, J. S.	Carlisle	Sullivan	Bush, Hargis R.	Cannelton	Perry
Brown, K. H.	New Albany	Floyd	Bussard, C. F.	South Bend	St. Joseph
Brown, Leland G.	Muncie	Delaware- Blackford	Bussard, Frank	South Bend	St. Joseph
			Butler, John O.	Indianapolis	Marion
Brown, Leo R.	Gary	Lake	Butler, Robert M.	c/o P.M., San Francisco	Marion
Brown, Marcel S.	Spencer	Owen- Monroe			
			Butterfield, Robt. M.	Muncie	Delaware- Blackford
Brown, R. E.	Cayuga	Parke- Vermillion			
			Buttz, Rose J.	Indianapolis	Marion
Brown, Robert L.	Evansville	Vanderburgh	Buxton, Eva (S)	Rockport	Spencer
Brown, Robert R.	Terre Haute	Vigo	Byrn, H. W.	New Albany	Floyd
Brown, Robert M.	Marion	Grant	Byrne, John M.	Delphi	Carroll
Brown, Stewart D.	Albany	Delaware- Blackford	Byrne, Robert J.	Bicknell	Knox
Brown, Thomas	Houston, Tex.	Carroll			
Brown, Thomas M.	Muncie	Delaware- Blackford			
Brown, Wendell E.	Indianapolis	Marion			
Browning, J. S.	Indianapolis	Marion			
Browning, W. M.	Indianapolis	Marion			
Brubaker, Harold S.	Huntington	Huntington			
Brubaker, O. G. (S)	N. Manchester	Wabash			
Bruegge, T. J.	Kokomo	Howard			

C

Cacia, John J.	Evansville	Vanderburgh
Cahn, Hugo M.	Indianapolis	Marion
Cajacob, Melville E.	Terre Haute	Vigo
Caldwell, Marilyn	Indianapolis	Marion
Caldwell, Milton V.	Terre Haute	Vigo
Caldwell, William C.	Evansville	Vanderburgh
Call, Earle B.	Knightstown	Henry
Call, H. F.	Indianapolis	Marion

Name	City	County	Name	City	County
Callaghan, W. C.	Greensburg	Decatur	Childs, Wallace E.	Madison	Jefferson-Switzerland
Callahan, R. H.	East Chicago	Lake	Christian, William A.	Indianapolis	Marion
Calli, Louis	North Vernon	Jennings	Christophel, Verna	Mishawaka	St. Joseph
Calvert, R. R.	Lafayette	Tippecanoe	Chroniak, Walter	Indianapolis	Marion
Calvin, Jessie C. (S)	Ft. Wayne	Allen	Clancy, J. F.	Hammond	Lake
Cameron, D. F.	Ft. Wayne	Allen	Clark, C. P.	Indianapolis	Marion
Cameron, Mary H.	Angola	Steuben	Clark, Fred O.	Syracuse	Kosciusko
Campagna, E. A.	East Chicago	Lake	Clark, Ivan A.	Paoli	Orange
Campbell, Guy G.	Munster	Lake	Clark, Lawson J.	Indianapolis	Marion
Campbell, J. A.	Indianapolis	Marion	Clark, M. E.	Cambridge City	Wayne-Union
Campbell, P. A.	Richmond	Wayne-Union	Clark, Stanley A. (S)	South Bend	St. Joseph
Campbell, Sam W.	Noblesville	Hamilton	Clark, William B., Jr.	Jeffersonville	Clark
Canaday, C. E. (S)	New Castle	Henry	Clark, Wm. H.	South Bend	St. Joseph
Canaday, J. W. (S)	Indianapolis	Marion	Clark, W. R.	Ft. Wayne	Allen
Canganelli, Vincent G.	Indianapolis	Marion	Clarke, Elton R.	Kokomo	Howard
Caplin, Irvin	Indianapolis	Marion	Clauser, E. H.	Muncie	Delaware-Blackford
Caplin, S. S.	Indianapolis	Marion	Clements, A. F.	Evansville	Vanderburgh
Carberry, George A.	Gary	Lake	Cleveland, John B.	Michigan City	LaPorte
Carbone, J. A.	Gary	Lake	Clevenger, J. H.	Muncie	Delaware-Blackford
Carey, W. W. (S)	Ft. Wayne	Allen	Clevinger, Wm. G.	Indianapolis	Marion
Carlberg, D. L.	Jeffersonville	Clark	Cline, Kenneth L.	Wyatt	St. Joseph
Carleton, E. H.	East Chicago	Lake	Close, W. D.	Indianapolis	Marion
Carlo, Ernest R.	Ft. Wayne	Allen	Clouse, Paul A.	Evansville	Vanderburgh
Carlo, J. F.	Hammond	Lake	Clunie, Wm. A.	Huntington	Huntington
Carlson, Charles E.	Chicago, Ill.	Marion	Coble, F. H.	Richmond	Wayne-Union
Carlson, E. A. (S)	Peru	Miami	Coble, R. R.	Indianapolis	Marion
Carlson, Norman C.	Michigan City	LaPorte	Cochran, Harry A., Jr.	Fort Wayne	Allen
Carlyle, Ivan E.	Michigantown	Clinton	Cockrum, Wm. M.	Evansville	Vanderburgh
Carmichael, C. S. (S)	Seelyville	Vigo	Coddens, A. L.	Earl Park	Benton
Carmody, R. F.	Gary	Lake	Cody, B. L.	Evansville	Vanderburgh
Carneal, Thomas E.	Winamac	Pulaski	Coffel, Melvin H.	Vincennes	Knox
Carney, J. T.	Jeffersonville	Clark	Coffman, Delmar Lee	Clinton, Okla.	Vanderburgh
Carney, John C.	Monticello	White	Cohn, Alvin C.	Indianapolis	Marion
Carpenter, G. C.	Terre Haute	Vigo	Cohen, Irving	Plainfield	Hendricks
Carpenter, J. L.	Alexandria	Madison	Cole, A. V.	East Chicago	Lake
Carpentier, Harry F.	Princeton	Gibson	Cole, Ira	Lafayette	Tippecanoe
Carrel, Francis E.	Frankfort	Clinton	Coleman, Floyd B.	Waterloo	Dekalb
Carroll, John C.	Decatur	Adams	Coleman, H. G.	Odon	Daviess-Martin
Carroll, Bertha Rose	W. Lafayette	Tippecanoe	Coleman, Joseph E.	Evansville	Vanderburgh
Carroll, Mary E.	Crown Point	Lake	Colglazier, G. G.	Leipsic	Orange
Carson, Wayne	Indianapolis	Marion	Colip, George	South Bend	St. Joseph
Carter, F. R. Nicholas	South Bend	St. Joseph	Collins, Hubert L.	Indianapolis	Marion
Carter, Fred S.	LaPorte	LaPorte	Collins, J. N.	Indianapolis	Marion
Carter, James C.	Indianapolis	Marion	Combs, Charles N.	Terre Haute	Vigo
Carter, J. V.	Tipton	Tipton	Combs, Herman	Evansville	Vanderburgh
Carter, Oren E.	Indianapolis	Marion	Combs, John H.	Evansville	Vanderburgh
Cartwright, E. L.	Ft. Wayne	Allen	Combs, Nelson B.	Mulberry	Clinton
Cartwright, Jack D.	San Antonio, Texas	LaPorte	Combs, Pearl B.	Evansville	Vanderburgh
Casebeer, P. B.	Clinton	Parke-Vermillion	Combs, Stuart R.	Terre Haute	Vigo
Caseley, Donald	Chicago, Ill.	Marion	Comeau, Wm. J.	Marion	Grant
Casey, Stanley M.	Huntington	Huntington	Comer, Charles W.	Mooreville	Morgan
Cassady, J. V.	South Bend	St. Joseph	Comer, Jonathan (S)	Mooreville	Morgan
Catlett, M. B.	Ft. Wayne	Allen	Comer, Kenneth E.	Mooreville	Morgan
Cavins, A. W.	Terre Haute	Vigo	Compton, C. B.	Los Angeles, Calif.	Clinton
Caylor, Harold D.	Bluffton	Wells	Compton, George	Tipton	Tipton
Caylor, Truman E.	Bluffton	Wells	Compton, Walter A.	Elkhart	Elkhart
Challman, W. B.	Mt. Vernon	Posey	Condit, David H.	South Bend	St. Joseph
Chambers, A. R.	Ft. Wayne	Allen	Congleton, G. C.	Terre Haute	Vigo
Chambers, L. B.	Union City	Randolph	Conklin, James O.	Terre Haute	Vigo
Chandler, L. H.	Goshen	Elkhart	Conklin, R. L.	Elkhart	Elkhart
Chappel, Alfred T.	Franklin	Johnson	Conley, John E.	Ft. Wayne	Allen
Chappell, Harold R.	Oakland City	Gibson	Conley, Joseph L.	Indianapolis	Marion
Chattin, Herbert O.	Vincennes	Knox	Conley, T. M.	Kokomo	Howard
Chattin, Robert E.	Loogootee	Daviess-Martin	Connell, P. S.	Plymouth	Marshall
Chattin, William R.	Indianapolis	Marion	Connell, Vactor O.	Bourbon	Marshall
Chattin, V. J.	Washington	Daviess-Martin	Connerley, M. L.	San Diego, Calif.	Marion
Cheydeur, Eleanor	Evansville	Vanderburgh	Connoy, Andrew F.	Westfield	Hamilton
Chen, K. K.	Indianapolis	Marion	Connoy, Leo	Westfield	Hamilton
Chereck, Edward J.	Muncie	Delaware-Blackford			
Chevigny, J. J.	Gary	Lake			
Chidlaw, B. W.	Hammond	Lake			
Childs, A. G. W. (S)	Madison	Jefferson-Switzerland			

Name	City	County	Name	City	County
Dearmin, R. M.	Indianapolis	Marion	Dodds, Wemple	Crawfordsville	Montgomery
DeArmond, Murray	Indianapolis	Marion	Doenges, James L.	Anderson	Madison
Decker, H. B.	Terre Haute	Vigo	Dolezal, Bernard J.	South Bend	St. Joseph
DeDario, L. M.	Elkhart	Elkhart	Dollens, Claude	Oolitic	Lawrence
Deems, Myers B.	Evansville	Vanderburgh	Dome, H. S. (S)	Tell City	Perry
Deer, Blan F.	Lake Worth, Fla.	Marion	Donahue, C. M.	Carmel	Hamilton
Deever, J. W.	Indianapolis	Marion	Donahue, G. R.	Lafayette	Tippecanoe
DeFries, John J.	New Paris	Elkhart	Donaldson, Frank C.	Anderson	Madison
DeGrazia, E. J.	Valparaiso	Porter	Donato, Albert M.	Indianapolis	Marion
DeHaven, Harry E.	Pleasantville, N. Y.	Rush	Donchess, J. C.	Gary	Lake
DeMotte, C. Bowen	Indianapolis	Marion	Donham, William L.	Bicknell	Knox
DeMotte, Russell A.	Bloomington	Owen- Monroe	Donnelly, Everett F.	South Bend	St. Joseph
DeNaut, J. F.	Knox	Starke	Donner, Paul G.	Hartf'd, Conn.	Marion
Denham, Robert H.	South Bend	St. Joseph	Doran, J. Hal	Indianapolis	Marion
Denman, R. D. (S)	Helmer	Steuben	Dorman, W. L.	Indianapolis	Marion
Denny, Edgar C.	Milton	Wayne- Union	Dorrance, T. O.	Bluffton	Wells
Denny, Fred C.	Madison	Jefferson- Switzerland	Doty, J. R.	Gary	Lake
Denny, Forrest L.	Indianapolis	Marion	Douglas, G. R. (S)	Valparaiso	Porter
Denny, Frank T.	Ladoga	Montgomery	Douglas, William T.	Montpelier	Delaware- Blackford
Denny, J. W.	Indianapolis	Marion	Dovey, Edward G.	Elkhart	Elkhart
Denny, Melvin H.	Rushville	Rush	Dowd, Joseph A.	Indianapolis	Marion
Denton, Larkin D.	Greentown	Howard	Dowell, E. H.	Rockville	Parke- Vermillion
Denzer, E. K.	Evansville	Vanderburgh	Downard, Leland F.	Gaston	Delaware- Blackford
Denzer, Wm. Oliver	Evansville	Vanderburgh	Dragoo, Farrol	Middletown	Henry
Deppe, Charles F.	Franklin	Johnson	Drake, John C.	Anderson	Madison
Derhammer, G. L.	Brookston	White	Drake, M. C.	Elwood	Madison
DeRyke, Gilbert R.	Winchester	Randolph	Drake, William L.	Indianapolis	Marion
DesJean, Paul A.	Indianapolis	Marion	Draper, M. H.	Maderia Beach, Fla.	Allen
Dester, Herbert E.	Jagdeeshpur, India	Marion	Dreyer, Ralph W.	Knights town	Henry
DeTar, G. B. (S)	Winslow	Pike	Dryden, Gale E.	Fort Totten, N. Dak.	Marion
Detrick, H. W.	Alamo, Tex.	Lake	Dublin, Madeline P.	Francesville	Pulaski
Dettloff, Frederick	Greencastle	Putnam	DuBois, Charles C. (S)	Warsaw	Kosciusko
Deutsch, Wm.	Muncie	Delaware- Blackford	Dubois, F. T. (S)	Liberty	Wayne- Union
DeVoe, Kenneth	Bluffton	Wells	Dubois, R. B.	Lafayette	Tippecanoe
DeWees, Dwight L.	Indianapolis	Marion	Duckworth, Alda G.	Indianapolis	Marion
Dewey, Fred N. (S)	Maumee, O.	Elkhart	Dudding, J. E.	Hope	Bartholomew- Brown
Dewey, Geo. W. (S)	Lafayette	Tippecanoe	Duemling, Arnold H.	Ft. Wayne	Allen
DeWitt, C. H. (S)	Valparaiso	Porter	Dugan, Thomas J. (S)	Indianapolis	Marion
Diamond, Leo	Marion	Grant	Dugan, Wm. M.	Indianapolis	Marion
Dian, A. J.	Gary	Lake	Duggan, J. A.	South Bend	St. Joseph
Dian, Julia G. Kuzmitz	Gary	Lake	Dukes, Betty	Dugger	Sullivan
Dickey, William M.	Pendleton	Madison	Dukes, David A.	Tell City	Perry
Dickson, D. D.	Greensburg	Decatur	Dukes, F. M.	Dugger	Sullivan
Dickinson, Gordon A.	Petersburg	Pike	Dukes, Joe E.	Dugger	Sullivan
Dieckman, Herbert S.	Evansville	Vanderburgh	Dunbar, Colin V.	Indianapolis	Marion
Diefendorf, Charles F. (S)	Evansville	Vanderburgh	Duncan, J. S.	Gary	Lake
Dielman, F. C.	Fulton	Fulton	Duncan, Raymond	Bedford	Lawrence
Dierdorf, Fred	Winslow	Pike	Dunlap, D. Logan	South Bend	St. Joseph
Dierolf, Edward J.	Gary	Lake	Dunn, F. W.	Muncie	Delaware- Blackford
Dietl, E. L.	South Bend	St. Joseph	Dunning, L. M.	Indianapolis	Marion
Dill, Myron K.	Indianapolis	Marion	Dunstone, H. C.	Ft. Wayne	Allen
Dillman, Carl E.	Corydon	Harrison- Crawford	Dupes, L. E.	Hobart	Lake
Dilts, Robert	Indianapolis	Marion	DuPuy, Charles M. (S)	Riley	Vigo
Dimmett, Robert P.	Boonville	Warrick	Durkee, M. S.	Evansville	Vanderburgh
Dingle, Paul	Richmond	Wayne- Union	Dusard, Joseph C.	Bedford	Lawrence
Dininger, W. S.	Winchester	Randolph	Dutchess, C. T.	Galveston	Cass
Dintaman, Paul G.	Indianapolis	Marion	DuVall, William N.	Mishawaka	St. Joseph
Dittmer, J. E.	Kouts	Porter	Dyar, E. W.	Indianapolis	Marion
Dittmer, Thomas L.	Valparaiso	Porter	Dycus, W. A.	Evansville	Vanderburgh
Ditton, I. W. (S)	Ft. Wayne	Allen	Dyer, G. W.	Terre Haute	Vigo
Dixon, Rex	Anderson	Madison	Dyer, Wallace K.	Evansville	Vanderburgh
Dobbs, O. R.	Greencastle	Putnam	Dyke, Richard W.	Indianapolis	Marion
Dodd, Robert D.	South Bend	St. Joseph	Dykhuisen, T. A.	Frankfort	Clinton
Dodd, Roberts K.	Evansville	Vanderburgh	E		
Dodds, James U.	Hartford City	Delaware- Blackford	Eades, R. Charles	Valparaiso	Porter
			Eades, Ralph C.	Valparaiso	Porter

Name	City	County	Name	City	County
Earl, Max M.	Kokomo	Howard	Entner, Charles L.	Connersville	Fayette-Franklin
Earp, Evanston B.	Indianapolis	Marion	Enzor, O. K.	Indianapolis	Marion
Eastman, J. R., Jr.	Indianapolis	Marion	Episcopo, A. R.	Salem	Washington
Eaton, E. R.	Indianapolis	Marion	Erdel, Milton W.	Frankfort	Clinton
Eaton, L. D.	Franklin	Johnson	Erehart, M. G.	Huntington	Huntington
Eaton, M. J.	Lafayette	Tippecanoe	Ericksen, Lester G.	South Bend	St. Joseph
Ebbinghouse, Tom	Richmond	Wayne-Union	Erickson, Gustaf W.	South Bend	St. Joseph
Ebert, J. Wayne	Indianapolis	Marion	Ericson, H. L.	Windfall	Tipton
Eberwein, J. H.	Indianapolis	Marion	Ernst, Clifford	Indianapolis	Marion
Ebin, Judah L.	South Bend	St. Joseph	Ernst, H. C.	East Chicago	Lake
Eby, Ida L.	Goshen	Elkhart	Estes, Ambrose C.	Bloomington	Owen-Monroe
Eckert, Russell A.	Chicago, Ill.	Marion	Evans, Frederick H.	Indianapolis	Marion
Eckles, Donald H.	Charlestown	Clark	Evans, Frederick J.	Clinton	Parke-Vermillion
Edlavitch, B. M.	Ft. Wayne	Allen	Evans, Paul V.	Indianapolis	Marion
Edmonds, Kendrick	Bedford	Lawrence	Evans, R. M.	Russiaville	Howard
Edwards, Bernard	South Bend	St. Joseph	Everly, Ralph	Indianapolis	Marion
Edwards, Edward T., Jr.	Vincennes	Knox	Eviston, J. V.	Huntington	Huntington
Edwards, W. F.	New Albany	Floyd	Ewbank, J. Nelson	Richmond	Wayne-Union
Egan, Sherman	South Bend	St. Joseph	Ewing, Nathaniel D.	Vincennes	Knox
Egbert, Herbert	Indianapolis	Marion			
Eggers, E. L.	Hammond	Lake		F	
Eggers, H. W.	Hammond	Lake	Fagaly, W. J.	Lawrenceburg	Dearborn-Ohio
Egnatz, Nicholas	Hammond	Lake	Failey, Robert	Indianapolis	Marion
Ehrich, W. S.	Evansville	Vanderburgh	Fair, Herbert D. (S)	Muncie	Delaware-Blackford
Ehrman, C. D.	Rockport	Spencer	Faith, I. L.	Newburgh	Warrick
Eicher, Palmer	Indianapolis	Marion	Faitin, Ladislaus	South Bend	St. Joseph
Eickenberry, H. W.	Indianapolis	Marion	Farabee, Charles R.	North Judson	Starke
Eisaman, Jack L.	Bluffton	Wells	Fargher, F. M.	Michigan City	La Porte
Eisenbarth, Elmer J.	Indianapolis	Marion	Fargher, R. A.	La Porte	La Porte
Eisenberg, D. A.	Martinsville	Morgan	Farnsworth, S. A.	La Porte	La Porte
Eisenlohr, Eugen	Terre Haute	Vigo	Farr, James	Martinsville	Morgan
Eisterhold, John A.	Evansville	Vanderburgh	Farrell, J. T.	Indianapolis	Marion
Eldridge, Gail E.	Indianapolis	Marion	Farris, John J.	Washington	Daviess-Martin
Elkins, James P.	A.P.O., San Francisco, Calif.	Bartholomew-Brown			
Elledge, Ray	Hammond	Lake	Faul, Henry J.	Evansville	Vanderburgh
Ellerbrook, George E.	Vevay	Jefferson-Switzerland	Faulkner, W. H.	Nashville, Tenn.	Wayne-Union
Ellett, John, Jr.	Coatesville	Hendricks	Fausset, C. Basil	Indianapolis	Marion
Elliott, John C.	Guilford	Dearborn-Ohio	Feerer, Donald J.	Michigan City	La Porte
Elliott, L. A.	Elkhart	Elkhart	Feferman, Martin E.	South Bend	St. Joseph
Elliott, Paul W.	Danville	Hendricks	Feinn, Harry S.	LaPorte	LaPorte
Elliott, R. A.	Gary	Lake	Feldman, Max	South Bend	St. Joseph
Elliott, Thomas A.	Elkhart	Elkhart	Fender, A. H.	Worthington	Greene
Ellis, Bert	Indianapolis	Marion	Fenneman, Robert J.	Evansville	Vanderburgh
Ellis, Davis W., Jr.	Rushville	Rush	Ferguson, A. N.	Fort Wayne	Allen
Ellis, George M.	Connersville	Fayette-Franklin	Ferguson, John T.	Logansport	Cass
Ellis, Lyman H.	Lizton	Hendricks	Ferguson, Wm. B.	W. Lafayette	Tippecanoe
Ellis, Seth	Anderson	Madison	Ferrara, Donald W.	Peru	Miami
Ellison, Alfred	South Bend	St. Joseph	Ferrara, Joseph F.	Franklin	Johnson
Elshout, Clem H.	LaPorte	LaPorte	Ferrara, S. J.	Peru	Miami
Elsner, L. W.	Seymour	Jackson	Ferrell, Mars B.	Fortville	Hancock
Elsten, A. W.	Anderson	Madison	Ferry, John L.	Whiting	Lake
Elston, L. W.	Ft. Wayne	Allen	Ferry, P. W.	Kokomo	Howard
Elston, Ralph W.	Ft. Wayne	Allen	Fessler, G. S.	Rising Sun	Dearborn-Ohio
Elward, Carl J.	Wabash	Wabash	Fichman, A. M.	Fort Wayne	Allen
Emenhiser, Donald C.	Woodburn	Allen	Fickas, Dallas	Evansville	Vanderburgh
Emenhiser, John L.	Fort Wayne	Allen	Fields, Don	Fowler	Benton
Emery, Charles B.	Bedford	Lawrence	Filipek, W. J.	South Bend	St. Joseph
Emhardt, J. W. A.	Indianapolis	Marion	Fincher, Robert C.	New Castle	Henry
Emhardt, John T.	Indianapolis	Marion	Fipp, August L.	Rome City	Noble
Emme, R. W.	Harlan	Allen	Firestein, Ben	South Bend	St. Joseph
Endicott, Wayne	Greenfield	Hancock	Firestein, Ray	Chicago, Ill.	St. Joseph
Engel, E. L.	Evansville	Vanderburgh	Fisch, Charles	Indianapolis	Marion
Engeler, J. E.	Lafayette	Tippecanoe	Fischer, Albert A.	Indianapolis	Marion
Engle, J. M.	Portland	Jay	Fischer, Burnell	Hammond	Lake
Engle, Russell B.	Winchester	Randolph	Fischer, C. N.	La Porte	La Porte
Engleman, H. K.	Georgetown	Floyd	Fischer, W. E.	Anderson	Madison
English, H. M.	Gary	Lake	Fish, C. M. (S)	South Bend	St. Joseph
English, J. P.	South Bend	St. Joseph	Fish, Edson C.	South Bend	St. Joseph
Ensminger, L. A. (S)	Indianapolis	Marion	Fisher, Gerald	Cleveland, O.	Marion

Name	City	County	Name	City	County
Fisher, Henry	Marion	Grant	Friedman, Leo	Brookline, Mass.	Vanderburgh
Fisher, John E.	Attica	Fountain-Warren	Friedman, Morris S.	South Bend	St. Joseph
Fisher, John E.	New Castle	Henry	Friedrich, Louis M. (S)	Hobart	Lake
Fisher, Lawrence F.	South Bend	St. Joseph	Frith, Gladys D.	South Bend	St. Joseph
Fisher, Walter S.	Columbus	Bartholomew-Brown	Frith, Louis G.	South Bend	St. Joseph
Fisher, William C.	Evansville	Vanderburgh	Fritsch, L. E.	Evansville	Vanderburgh
Fisk, Frank B.	Tarrytown, N. Y.	Marion	Fromhold, Willis A.	Houston, Tex.	Marion
Fitzgerald, Brice E.	Logansport	Cass	Frost, Robert J.	Michigan City	LaPorte
Fitz Gerald, Maurice D.	Evansville	Vanderburgh	Fruth, Rodney B.	Connersville	Fayette-Franklin
Fitzgerald, William J.	Indianapolis	Marion	Fruth, Virgil T.	Connersville	Fayette-Franklin
Fitzpatrick, Harry W.	Elwood	Madison	Fry, Robert D.	Indianapolis	Marion
Fitzpatrick, James S.	Portland	Jay	Frybarger, S. S.	Converse	Miami
Fitzsimmons, E. L.	Evansville	Vanderburgh	Fullerton, R. L.	Indianapolis	Marion
Flack, Russell A.	Lafayette	Tippecanoe	Funk, John W.	Muncie	Delaware-Blackford
Flaherty, Walter T.	Michigan City	La Porte	Funkhouser, A. G.	Indianapolis	Marion
Flanagan, E. P.	Walton	Cass	Funkhouser, Elmer	Indianapolis	Marion
Flanigan, M. B.	Indianapolis	Marion	Fuqua, Harold B.	Terre Haute	Vigo
Flannigan, H. F.	LaGrange	Elkhart	Furgason, Paul C.	Indianapolis	Marion
Fleetwood, R. A.	Nappanee	Elkhart	Fuson, W. J.	Greencastle	Putnam
Fleischer, J. C.	East Chicago	Lake		G	
Fleming, C. F.	Elkhart	Elkhart	Gabe, Wm. E.	Indianapolis	Marion
Fleming, Justus M.	Elkhart	Elkhart	Galante, Vincent J.	Chicago, Ill.	Lake
Fletcher, Charles F.	Sunman	Ripley	Galbreath, R. S.	Huntington	Huntington
Flick, John J.	Indianapolis	Marion	Galbreath, J. P. (S)	Burnettsville	White
Flora, Joseph O.	Indianapolis	Marion	Galliher, Marjorie J.	Muncie	Delaware-Blackford
Folck, J. K.	Princeton	Gibson	Gallup, Palmer R.	Indianapolis	Marion
Folkening, N. C.	Indianapolis	Marion	Gambill, Wm. D.	Indianapolis	Marion
Foltz, Lloyd E.	Brownsburg	Hendricks	Gammieri, Robert L.	Indianapolis	Marion
Forbes, Violet Crabbe	Wolcott	White	Gannon, G. W.	Gary	Lake
Foreman, Harry L.	Indianapolis	Marion	Ganser, Richard A.	Mishawaka	St. Joseph
Foreman, Walter A.	Brookville	Fayette-Franklin	Gante, H. W.	Anderson	Madison
Forry, Frank	Indianapolis	Marion	Ganz, Max	Marion	Grant
Forsee, Norman E.	Jeffersonville	Clark	Garber, E. C.	Dunkirk	Jay
Forsyth, D. H. (S)	Terre Haute	Vigo	Garber, J. Neill	Indianapolis	Marion
Fortier, Edward G.	East Chicago	Lake	Garceau, George J.	Indianapolis	Marion
Fosbrink, E. L.	Syracuse	Kosciusko	Gard, Daniel A.	Marshall	Parke-Vermillion
Fosgate, Orville E.	Indianapolis	Marion	Gardiner, H. Glenn	East Chicago	Lake
Foster, Lee N.	Indianapolis	Marion	Gardiner, Sprague H.	Indianapolis	Marion
Foster, Ray T.	New Castle	Henry	Gardner, Buckman	Indianapolis	Marion
Foster, Robert	Franklin	Johnson	Gardner, M. D.	Michigan City	La Porte
Fountaine, Thomas J.	Bedford	Lawrence	Gardner, Russell A.	Michigan City	La Porte
Fouts, Paul J.	Indianapolis	Marion	Garfield, M. D.	Indianapolis	Marion
Fowler, Richard R.	Bloomington	Owen-Monroe	Garland, Edgar	Evansville	Vanderburgh
Fox, C. Philip	Washington	Daviess-Martin	Garling, L. C.	Muncie	Delaware-Blackford
Fox, Maurice S.	Vincennes	Knox	Garner, William (S)	Indianapolis	Marion
Fox, R. H. (S)	Bicknell	Knox	Garner, W. Stanley	Indianapolis	Marion
Foy, H. W.	Fort Wayne	Allen	Garner, Wm. H.	New Albany	Floyd
Frank, J. R.	Valparaiso	Porter	Garrett, John D. (S)	Indianapolis	Marion
Frank, L. L.	South Bend	St. Joseph	Garrett, Robert A.	Indianapolis	Marion
Franklin, William L.	Indianapolis	Marion	Garrison, James L.	Cumberland	Marion
Frankowski, Clementine	Whiting	Lake	Garrison, Leon J.	Gas City	Grant
Frantz, Mount E.	Danville	Hendricks	Garton, H. W.	Ft. Wayne	Allen
Frasch, M. G.	Lafayette	Tippecanoe	Gaskill, Herbert S.	Denver, Colo.	Marion
Frash, De Von W.	South Bend	St. Joseph	Gastineau, David C.	Indianapolis	Marion
Frazin, Bernard	Indianapolis	Marion	Gastineau, F. M.	Indianapolis	Marion
Freeborn, Warren S.	Indianapolis	Marion	Gatch, W. D.	Indianapolis	Marion
Freed, Carl A.	Attica	Fountain-Warren	Gates, George E.	South Bend	St. Joseph
Freed, James C.	Attica	Fountain-Warren	Gaul, L. Edward	Evansville	Vanderburgh
Freed, John E., Sr.	Terre Haute	Vigo	Gaunt, Everett W.	Alexandria	Madison
Freed, John E., Jr.	Terre Haute	Vigo	Geckler, Charles E.	Muncie	Delaware-Blackford
Freeman, F. M.	Goshen	Elkhart	Gehres, R. W.	Shelbyville	Shelby
Freeman, Max E.	Indianapolis	Marion	Geick, Raymond	Fort Branch	Gibson
French, Wm. G.	Evansville	Vanderburgh	Geider, Roy A.	Indianapolis	Marion
Frey, Harley B.	Lafayette	Tippecanoe	Geiger, Dillon	Bloomington	Owen-Monroe
Frey, William B.	South Bend	St. Joseph	Geisinger, L. N. (S)	Auburn	De Kalb
Friedman, David K.	Houston, Tex.	Marion	Geller, Samuel	Owensville	Gibson
Friedman, Isadore E.	Hammond	Lake			

Name	City	County	Name	City	County
Genovese, Pasquale	Indianapolis	Marion	Gordon, Joseph L.	Wheeler	Porter
Gentile, John P.	New Albany	Floyd	Gordon, J. M. (S)	South Bend	St. Joseph
George, Charles L.	Indianapolis	Marion	Gosman, James H.	Indianapolis	Marion
Gerding, William J.	Fort Wayne	Allen	Gossard, Meredith B.	Tipton	Tipton
Gerrish, D. A.	Terre Haute	Vigo	Gossom, Donn R.	Terre Haute	Vigo
Gerrish, W. D.	Clinton	Parke- Vermillion	Gould, L. K.	Ft. Wayne	Allen
Gery, Richard E.	Lafayette	Tippecanoe	Govorchin, Alexander	East Chicago	Lake
Getty, William H.	Evansville	Vanderburgh	Graessle, Harold P.	Seymour	Jackson
Gevirtz, M. B.	Hammond	Lake	Graf, John E.	Chicago, Ill.	Marion
Gibbs, Charles (S)	Greenfield	Hancock	Graf, John P.	South Bend	St. Joseph
Gibbs, Joseph W.	Martinsville	Morgan	Graf, Jerome A.	Bloomfield	Greene
Gibson, Greta	Indianapolis	Marion	Graham, George M.	Ft. Wayne	Allen
Gick, Herman	Indianapolis	Marion	Grant, Albert J.	North Judson	Starke
Gifford, F. E.	Indianapolis	Marion	Grant, Benjamin F.	Gary	Lake
Gilbert, Ivan	Terre Haute	Vigo	Grant, John H.	Evansville	Vanderburgh
Gilkison, William L. (S)	Shoals	Daviess- Martin	Grant, M. Arthur	Fairmount	Grant
Gill, Bernard P.	Evansville	Vanderburgh	Graves, J. W.	Indianapolis	Marion
Gill, Dee Dar	Greenfield	Hancock	Graves, Noel S.	Vevay	Jefferson- Switzerland
Gill, Thomas A.	Muncie	Delaware- Blackford	Graves, Orville M.	Princeton	Gibson
Gillespie, Chas. E. (S)	Seymour	Jackson	Gray, Clyde C.	Cloverdale	Putnam
Gillespie, Chas. F.	Indianapolis	Marion	Gray, D. E.	Crown Point	Lake
Gillespie, G. R.	Brownstown	Jackson	Gray, Leon	Martinsville	Morgan
Gillespie, J. E.	Indianapolis	Marion	Gray, Paul M.	Huntington	Huntington
Gillespie, J. F. (S)	Greencastle	Putnam	Grayston, Wallace S. (S)	Huntington	Huntington
Gillette, Edward P.	Indianapolis	Marion	Green, Carl L.	Vincennes	Knox
Gillette, Walter R.	Bluffton	Wells	Green, F. H., Jr.	Rushville	Rush
Gilliatt, J. P.	Salem	Washington	Green, George F.	South Bend	St. Joseph
Gillum, John R. (S)	Terre Haute	Vigo	Green, John H.	North Vernon	Jennings
Gilman, M. M.	South Bend	St. Joseph	Green, Harrison	Indianapolis	Marion
Gilmore, Louis (S)	Vincennes	Knox	Green, Leonard J.	Valparaiso	Porter
Gilmore, R. A.	Michigan City	La Porte	Green, Norval E.	South Bend	St. Joseph
Gilmore, Robert W.	Michigan City	LaPorte	Green, Oscar	Indianapolis	Marion
Gingerick, Chas. M.	Liberty Center	Wells	Green, Wm. L. (S)	Pekin	Washington
Ginsberg, Stewart	Marion	Grant	Greenbank, Richard K.	Indianapolis	Marion
Giordano, A. S.	South Bend	St. Joseph	Greenburg, Rolland	Jasper	Dubois
Girod, Arthur H.	Decatur	Adams	Greene, Claude D.	Spencer	Owen-Monroe
Gish, Howard M.	Brookston	White	Greene, Frederick G.	Bloomingsdale	Parke- Vermillion
Gitlin, Max M.	Bluffton	Wells	Greene, Morgan E.	Indianapolis	Marion
Gitlin, Wm. A.	Bluffton	Wells	Greene, Wm. R.	Henryville	Clark
Givner, David	Indianapolis	Marion	Gregg, Albert F.	Connersville	Fayette- Franklin
Glackman, J. C., Jr.	Rockport	Spencer	Gregg, Edwin E.	Thorntown	Boone
Glackman, J. C., Sr.	Rochester	Fulton	Gregoline, A. F.	Gary	Lake
Gladstone, N. H.	Fort Wayne	Allen	Gregory, Charles F.	San Francisco, Calif.	Marion
Glass, R. L.	Indianapolis	Marion	Greiber, Marvin F.	Muncie	Delaware- Blackford
Glendening, J. L.	Indianapolis	Marion	Greip, Arthur H.	Evansville	Vanderburgh
Glendening, Richard L.	Spring- field, Ill.	Marion	Greisen, Jack G.	Whiting	Lake
Glenn, Fred C.	Tell City	Perry	Greist, H. W. (S)	Monticello	White
Glick, Julius	Walkerton	St. Joseph	Greist, John	Indianapolis	Marion
Glock, H. E. (S)	Fort Wayne	Allen	Greist, Oliver E.	Ft. Lauderdale, Fla.	Tippecanoe
Glock, M. E.	Ft. Wayne	Allen	Greist, Walter D.	Fort Wayne	Allen
Glock, Wayne R.	Ft. Wayne	Allen	Griffin, J. P.	Chesterton	Porter
Glosson, Jack R.	Clay City	Clay	Griffis, V. C.	Richmond	Wayne-Union
Gobbel, N. E.	English	Harrison- Crawford	Griffith, Harold	Indianapolis	Marion
Goebel, Carl W.	Fort Wayne	Allen	Griffith, James W.	Sheridan	Hamilton
Godersky, George E.	South Bend	St. Joseph	Griffith, R. E.	Indianapolis	Marion
Goethals, Charles J.	Mishawaka	St. Joseph	Griffith, Richard S.	Indianapolis	Marion
Goldberg, Harold B.	Gary	Lake	Grillo, Donald	South Bend	St. Joseph
Goldman, Samuel	Indianapolis	Marion	Gripe, R. P.	Lafayette	Tippecanoe
Goldstone, Adolph	Gary	Lake	Grisell, Ted L.	Indianapolis	Marion
Goldstone, Joseph	Gary	Lake	Griswold, W. R.	San Diego, Calif.	Marion
Goldstone, S. R.	Gary	Lake	Groman, Herman C.	Hammond	Lake
Golper, Marvin N.	Kokomo	Howard	Grosso, W. G.	East Chicago	Lake
Good, R. P.	Kokomo	Howard	Grorud, Alton C.	South Bend	St. Joseph
Goodman, Eli	Charlestown	Clark	Grotts, Bruce F.	Michigan City	LaPorte
Goodman, H. T.	Terre Haute	Vigo	Grove, Robert H.	Rossville	Clinton
Goodwin, Caroline J.	Indianapolis	Marion	Gunderson, Shaun D.	Omaha, Neb.	Marion
Goodwin, C. B. (S)	Kendallville	Noble	Gustafson, Carl J.	Marion	Grant
Gootee, Francis H.	Indianapolis	Marion	Gustafson, G. W.	Indianapolis	Marion
Goralka, Joseph J.	East Gary	Lake			

Name	City	County	Name	City	County
Gustafson, Milton	Muncie	Delaware-Blackford	Hare, Laura	Indianapolis	Marion
Gustaitis, John W.	East Chicago	Lake	Harger, Robert W.	Indianapolis	Marion
Gutelius, C. B. (S)	Indianapolis	Marion	Harkcom, H. E.	St. Paul	Decatur
Guthrie, F. C.	Vero Beach, Fla.	Madison	Harkness, R. G.	Terre Haute	Vigo
Guthrie, James U.	Nellis A.F.B., Nevada	Marion	Harless, Clarence M.	Chesterton	Porter
Gutstein, Richard R.	Kendallville	Noble	Harmon, C. J.	Richmond	Wayne-Union
Gwaltney, L. F.	Roachdale	Putnam	Harmon, Gladys H.	Richmond	Wayne-Union
Gwin, Merle D.	Miami Beach, Fla.	Jasper-Newton	Harmon, Vachelle E.	South Bend	St. Joseph
H			Harmon, Wayne	Lynn	Randolph
Habegger, Myron L.	Cocoa, Fla.	Adams	Harold, A. H. (S)	Indianapolis	Marion
Habich, Carl	Indianapolis	Marion	Harold N. E. (S)	Indianapolis	Marion
Hack, E. C.	Hammond	Lake	Harris, Carl B.	Indianapolis	Marion
Hade, Frederick L.	Bridgeport	Marion	Harris, Howard H.	Terre Haute	Vigo
Hadley, David	Indianapolis	Marion	Harris, Paul N.	Indianapolis	Marion
Hadley, Murray N. (S)	Indianapolis	Marion	Harris, R. F.	Noblesville	Hamilton
Haffner, H. G.	Ft. Wayne	Allen	Harrison, B. L.	New Castle	Henry
Haggard, E. B.	Indianapolis	Marion	Harshman, L. P.	Ft. Wayne	Allen
Hahn, E. V.	Indianapolis	Marion	Harshman, Martin L.	Lafayette	Tippecanoe
Haley, Paul E.	South Bend	St. Joseph	Harstad, Casper	Rockville	Parke-Vermillion
Halfast, Richard W.	Kokomo	Howard	Hart, L. Paul	Evansville	Vanderburgh
Hall, Bernard R.	Logansport	Cass	Hart, Robert B.	Columbus	Bartholomew-Brown
Hall, E. H.	Dunkirk	Jay	Hart, Wm. D.	Anderson	Madison
Hall, Frank M.	Indianapolis	Marion	Harter, Eli Blair	Lafayette	Tippecanoe
Hall, Jack R.	Indianapolis	Marion	Hartley, C. A., Jr.	Evansville	Vanderburgh
Hall, James M.	South Bend	St. Joseph	Hartman, John	Angola	Steuben
Hall, Orville A.	Muncie	Delaware-Blackford	Hartz, F. Minton	Evansville	Vanderburgh
Hall, Thomas C.	Chesterton	Porter	Harvey, Harry C.	Ft. Wayne	Allen
Halleck, H. J.	Winamac	Pulaski	Harvey, R. J.	Zionsville	Boone
Haller, Robert L.	Fort Wayne	Allen	Harvey, Verne K.	Alexandria, Va.	Marion
Haller, Thomas C.	Crawfordsville	Montgomery	Hasewinkle, A. M.	Ft. Wayne	Allen
Hamer, Homer G.	Indianapolis	Marion	Hasewinkel, Carroll	Indianapolis	Marion
Hamilton, Antha A.	Shelburn	Sullivan	Hash, John S.	Noblesville	Hamilton
Hamilton, Charles O.	South Bend	St. Joseph	Haslem, Ezra R.	Terre Haute	Vigo
Hamilton, Emory D.	Ft. Wayne	Allen	Haslem, John R.	Terre Haute	Vigo
Hamilton, Guy (S)	Durato, Calif.	Jefferson-Switzerland	Haslinger, C. J.	Indianapolis	Marion
Hamilton, J. R.	Mitchell	Lawrence	Hastings, Warren C.	Ft. Wayne	Allen
Hamilton, M. Luther	Newberry	Greene	Hatfield, B. F.	Indianapolis	Marion
Hamilton, Orville G.	Bluffton	Wells	Hatfield, Jack J.	Indianapolis	Marion
Hamilton, Robert C.	East Chicago	Lake	Hatfield, Margaret	Indianapolis	Marion
Hamilton, Thomas	Columbia City	Whitley	Hatfield, N. W.	Indianapolis	Marion
Hammel, Howard T.	Bedford	Lawrence	Hathaway, Clayton B.	Butler	DeKalb
Hammer, Jay Wm.	Middletown	Henry	Hattendorf, A. P.	Ft. Wayne	Allen
Hammersley, Geo. K.	Frankfort	Clinton	Haugseth, Ellsworth K.	South Bend	St. Joseph
Hammond, Keith	Paoli	Orange	Hauss, Augustus P.	New Albany	Floyd
Hammond, R. Case	Evansville	Vanderburgh	Havens, Oscar	Cicero	Hamilton
Hammond, Stanley M.	Portland	Jay	Havens, R. E.	Ft. Wayne	Allen
Hampshire, Don R.	Indianapolis	Marion	Havice, Jay F.	Lake Lure, N. C.	Allen
Hancock, John G.	Indianapolis	Marion	Hawes, J. K. (S)	Columbus	Bartholomew-Brown
Hanley, Edward J.	Indianapolis	Marion	Hawes, M. E.	Columbus	Bartholomew-Brown
Hann, Eldon C.	Indianapolis	Marion	Hawk, James H.	Indianapolis	Marion
Hanna, Duke E., Jr.	Indianapolis	Marion	Hayes, Jess D.	East Chicago	Lake
Hanna, T. A.	Indianapolis	Marion	Hayes, T. R.	Muncie	Delaware-Blackford
Hannah, Jack W.	Wakarusa	Elkhart	Haymond, George N.	Warsaw	Kosciusko
Hansell, R. M.	Indianapolis	Marion	Haymond, Joseph L.	Indianapolis	Marion
Hansen, A. H.	Hammond	Lake	Hays, Everett L.	Indianapolis	Marion
Hanson, Martin F.	Elwood	Madison	Hays, George R.	Richmond	Wayne-Union
Harcourt, A. K.	Indianapolis	Marion	Hazinski, R. T.	Griffith	Lake
Harden, Murray E.	Lafayette	Tippecanoe	Headley, L. M.	Lebanon	Boone
Hardin, W. E.	Ossian	Wells	Heard, Albert	Evansville	Vanderburgh
Harding, M. Richard	Indianapolis	Marion	Heck, Martin C.	Jasper	Dubois
Harding, Myron S.	Indianapolis	Marion	Heck, Rolfe A.	College Corner, Ohio	Wayne-Union
Hardtke, Eldred F.	Bloomington	Owen-Monroe	Hedde, E. L.	Logansport	Cass
Hardy, John J.	North Liberty	St. Joseph	Hedgcock, R. A.	Frankfort	Clinton
Hare, Daniel M.	Evansville	Vanderburgh	Hedrick, James T.	Gary	Lake
Hare, E. H.	Indianapolis	Marion			
Hare, Francis W., Jr.	Madison	Jefferson-Switzerland			

Name	City	County	Name	City	County
Hedrick, Philip W.	Indianapolis	Marion	Hillenbrand, Charles	Michigan City	LaPorte
Hefti, Karl R.	Evansville	Vanderburgh	Hillery, John L.	Warsaw	Kosciusko
Heilman, W. C.	New Castle	Henry	Hillis, L. J.	Logansport	Cass
Heinrich, Weston A.	Evansville	Vanderburgh	Hillman, Marion W.	South Bend	St. Joseph
Heinrichs, Harry H.	Indianapolis	Marion	Hillman, W. H. (S)	South Bend	St. Joseph
Heinz, Dorothy C. V.	Baltimore, Md.	Marion	Hillsamer, Phyllis G.	Indianapolis	Marion
Held, George A.	Jasper	Dubois	Himebaugh, Gilbert	Veedersburg	Fountain- Warren
Heller, N. L.	Dunkirk	Jay	Himebaugh, J. R. S.	Indianapolis	Marion
Helmen, H. W.	South Bend	St. Joseph	Himler, James M.	Indianapolis	Marion
Helmer, John F.	South Bend	St. Joseph	Hinchman, C. P.	Geneva	Adams
Henderson, Arvin	Ridgeville	Randolph	Hinchman, Jean F.	Parker	Randolph
Henderson, Eugene L.	Evansville	Vanderburgh	Hine, U. B.	Indianapolis	Marion
Henderson, Francis G.	Indianapolis	Marion	Hines, A. V.	Auburn	DeKalb
Henderson, N. C.	Michigan City	LaPorte	Hines, Don C.	Indianapolis	Marion
Henderson, R. A.	Muncie	Delaware- Blackford	Hippensteel, Harland	Auburn	DeKalb
Hendricks, John D. (S)	Indianapolis	Marion	Hippensteele, Ralph	Fremont	Steuben
Hendricks, John W.	Indianapolis	Marion	Hisrich, L. W.	Batesville	Ripley
Hendrix, Claude	Waveland	Montgomery	Hobbs, Arthur	Evansville	Vanderburgh
Henley, Glenn (S)	Fairmount	Grant	Hochhalter, Marian	Logansport	Cass
Henn, R. Anthony	Greenfield	Hancock	Hodges, Fletcher (S)	Indianapolis	Marion
Hennessee, Philip C.	Indianapolis	Marion	Hodges, Wm. A.	Oaktown	Knox
Henning, Carl	Hanover	Jefferson- Switzerland	Hodgin, Phillip	Orleans	Orange
Henry, Alvin L.	Columbus	Bartholomew- Brown	Hodurski, Zigfield	Gary	Lake
Henry, Howard J.	Knox	Starke	Hoffman, A. F.	Ft. Wayne	Allen
Henry, Russell S.	Indianapolis	Marion	Hoffman, Doris	Vincennes	Knox
Hensler, B. M.	Anderson	Madison	Hoffman, Herman	Indianapolis	Marion
Hepburn, C. K.	Indianapolis	Marion	Hoffman, R. V.	South Bend	St. Joseph
Hepner, H. S.	Bloomington	Owen- Monroe	Hoffmann, S. P., Sr.	Ft. Wayne	Allen
Herd, Cloyn R.	Peru	Miami	Hofmann, Andrew (S)	Hammond	Lake
Herendeen, E. V.	Rochester	Fulton	Hofmann, J. Wm.	Indianapolis	Marion
Heritier, C. Jules	Columbia City	Whitley	Hogle, Frank D.	Logansport	Cass
Hermayer, Stephen	Evansville	Vanderburgh	Holdeman, Lillian	South Bend	St. Joseph
Herr, John W.	Mt. Vernon	Posey	Holdeman, R. W.	South Bend	St. Joseph
Herrick, C. L.	Akron	Fulton	Holladay, L. J.	Lafayette	Tiptecanoe
Herring, G. N.	Richmond	Wayne-Union	Holland, Chas. E.	Bloomington	Owen- Monroe
Herrmann, Gordon T.	Evansville	Vanderburgh	Holland, D. J. (S)	Bloomington	Owen- Monroe
Herrold, G. W.	Lafayette	Tiptecanoe	Holland, Philip	Bloomington	Owen- Monroe
Hershey, E. A.	Churubusco	Whitley	Hollingsworth, A. A.	Indianapolis	Marion
Herzberg, Milton	Clinton	Parke- Vermillion	Hollingsworth, Marshall P. (S)	Princeton	Gibson
Herzer, C. C.	Evansville	Vanderburgh	Hollis, Walter H.	Ft. Branch	Gibson
Hess, Paul P.	New Albany	Floyd	Holloway, W. A. (S)	Logansport	Cass
Hetherington, A. M.	Indianapolis	Marion	Holman, J. E., Sr.	Indianapolis	Marion
Hetherington, John A.	Indianapolis	Marion	Holman, J. E., Jr.	Indianapolis	Marion
Hetman, Mitchell J.	Westville	LaPorte	Holmes, Claude D.	Indianapolis	Marion
Heubi, John E.	Indianapolis	Marion	Holmes, Claude D., Sr.	Frankfort	Clinton
Hiatt, R. L.	Ft. Wayne	Allen	Holmes, G. W.	Gary	Lake
Hibner, Nolan A.	Monticello	White	Holmes, John L.	Seattle, Wash.	Clinton
Hickman, A. Lee	Hammond	Lake	Holsinger, R. E.	Indianapolis	Marion
Hickman, Walter	Indianapolis	Marion	Holt, Everett L.	Indianapolis	Marion
Hicks, Joseph (S)	Arcadia	Hamilton	Holtzman, Paul W.	Gosport	Owen- Monroe
Hiestand, H. J.	Pennville	Jay	Honan, Paul R.	Lebanon	Boone
Higbee, Paul	Sullivan	Sullivan	Hood, Ainslee A.	Indianapolis	Marion
Higgins, James L.	Petersburg	Pike	Hooke, Sam W.	Noblesville	Hamilton
Higgins, John R.	New Albany	Floyd	Hoopes, Jane	Evansville	Vanderburgh
High, Ralph L.	Muncie	Delaware- Blackford	Hoover, Ammon W.	Michigan City	LaPorte
Hilbert, John W.	South Bend	St. Joseph	Hoover, D. A.	Terre Haute	Vigo
Hildebrand, John O., Jr.	Indianapolis	Marion	Hoover, Peter B.	Boonville	Warrick
Hildebrand, W. O. (S)	Topeka	LaGrange	Hopkins, J. R.	Hammond	Lake
Hill, H. D.	Richmond	Wayne- Union	Hopkins, Lester H.	Versailles	Ripley
Hill, H. E.	Muncie	Delaware- Blackford	Hoppenrath, Wesley M.	Elwood	Madison
Hill, Kenneth G.	New Castle	Henry	Hoppenrath, Wm. (S)	Elwood	Madison
Hill, Paul G.	Cambridge City	Wayne-Union	Horst, William N.	Crown Point	Lake
Hill, Robert	Muncie	Delaware- Blackford	Horswell, R. G.	Bristol	Elkhart
Hill, T. N.	Scottsburg	Scott	Horwitz, Thomas	Indianapolis	Marion
Hill, Theodore A.	South Bend	St. Joseph	Hostetler, Carl M.	Goshen	Elkhart
Hilldrup, Don G.	Indianapolis	Marion	Hostetter, Irwin S.	Muncie	Delaware- Blackford

Name	City	County
Houser, D. Stanley	Lakeville	St. Joseph
Houser, Wayne W.	Monon	White
Houseworth, John H.	Aurora, Calif.	Marion
Houston, Fred D.	Lawrenceburg	Dearborn-Ohio
How, John T. (S)	Lakeville	St. Joseph
How, Louis E.	South Bend	St. Joseph
Howard, W. H.	Hammond	Lake
Howe, Fordyce L.	Ft. Wayne	Allen
Howell, Joseph D.	Indianapolis	Marion
Howell, R. D.	Indianapolis	Marion
Hoyt, Lester H.	Indianapolis	Marion
Huber, Carl P.	Indianapolis	Marion
Huckleberry, Carl D.	Cloverdale	Putnam
Huckleberry, Irvin	Salem	Washington
Huddle, John R.	Indianapolis	Marion
Hudson, Foster J.	Indianapolis	Marion
Huffman, A. D.	Acton	Marion
Huffman, V. P.	South Whitley	Whitley
Hughes, Richard R.	Lafayette	Tippecanoe
Hughes, W. F. (S)	Indianapolis	Marion
Huggins, Victor S.	Evansville	Vanderburgh
Hull, A. W.	Elkhart	Elkhart
Hull, James E.	Indianapolis	Marion
Hull, Ronald H.	Indianapolis	Marion
Hummel, R. M.	Marion	Grant
Hummell, Paul	Oakville	Delaware-Blackford
Hummons, Francis D.	Indianapolis	Marion
Hummons, Henry L.	Indianapolis	Marion
Humphrey, Paul E.	Terre Haute	Vigo
Humphreys, Joe E.	Vincennes	Knox
Humphreys, John W.	Crawfordsville	Montgomery
Hunsberger, W. G.	Lafayette	Tippecanoe
Hungerford, Louis N.	Indianapolis	Marion
Hunt, Edgar J.	Terre Haute	Vigo
Hunt, Gayle J.	Richmond	Wayne-Union
Hunter, Donn	Greenfield	Hancock
Hunter, F. P.	Lafayette	Tippecanoe
Hunter, Lowell G.	Milan	Ripley
Huoni, J. S.	Jeffersonville	Clark
Hurley, Anson	Muncie	Delaware-Blackford
Hurley, John R.	Daleville	Delaware-Blackford
Hurt, L. B.	Indianapolis	Marion
Huse, William M.	Indianapolis	Marion
Husted, Robert	Hammond	Lake
Hutchison, Donald R.	Fountain City	Wayne-Union
Hutto, W. H.	Kokomo	Howard
Hyatt, Gilbert T.	Evansville	Vanderburgh
Hyde, Carroll	South Bend	St. Joseph
Hynes, Roy T.	Indianapolis	Marion
I		
Ikins, R. G.	Lafayette	Tippecanoe
Imhof, Joseph D.	Muncie	Delaware-Blackford
Ingwell, Guy B.	Knox	Starke
Inlow, Herbert	Shelbyville	Shelby
Inlow, W. D.	Shelbyville	Shelby
Irey, P. R.	Plymouth	Marshall
Irish, Wilbur J.	East Chicago	Lake
Irwin, Glenn W., Jr.	Indianapolis	Marion
Irwin, Seth	Anderson	Madison
Iske, Paul G.	Indianapolis	Marion
Isler, N. C.	Jeffersonville	Clark
Iterman, G. E.	New Castle	Henry
Ives, R. J.	Francesville	Pulaski
J		
Jackson, Charles E.	Bluffton	Wells
Jackson, Dean B.	Hartford City	Delaware-Blackford
Jackson, F. E.	Indianapolis	Marion

Name	City	County
Jackson, James W.	Indianapolis	Marion
Jackson, Jesse L.	Indianapolis	Marion
Jackson, John F.	Fort Wayne	Allen
Jackson, J. K.	Aurora	Dearborn-Ohio
Jacobs, George C.	Kentland	Jasper-Newton
Jaeger, A. S. (S)	Indianapolis	Marion
Jahns, Albin A.	Gary	Lake
James, N. A.	Tell City	Perry
James, Thomas, Jr.	Huntington	Huntington
Jannasch, Maurice C.	Gary	Lake
Jaquith, O. S. (S)	Indianapolis	Marion
Jarrett, John C.	Marion	Grant
Jarrett, Paul E.	Fairchild, Wash.	Madison
Jay, Arthur N.	Indianapolis	Marion
Jean, Thomas A.	Morristown	Shelby
Jeffries, K. I.	Indianapolis	Marion
Jenkins, Robert E.	Indianapolis	Marion
Jennings, Frank	Indianapolis	Marion
Jewell, Earl B.	Logansport	Cass
Jewell, George M.	Kokomo	Howard
Jewett, Joe H.	Indianapolis	Marion
Jewett, Laurence (S)	Excelsior Springs, Mo.	Wabash
Jewett, Robert E.	Wabash	Wabash
Jinks, C. H.	Indianapolis	Marion
Jinnings, Loren E.	Garrett	DeKalb
Jobes, James E.	Indianapolis	Marion
Jobes, N. E. (S)	Indianapolis	Marion
Joest, Charles O.	Connerville	Fayette-Franklin
Johns, D. R.	East Chicago	Lake
Johns, N. C.	South Bend	St. Joseph
Johnson, C. E.	Rensselaer	Jasper-Newton
Johnson, Earl E.	Covington	Fountain-Warren
Johnson, F. D.	Waynetown	Montgomery
Johnson, G. C. (S)	Evansville	Vanderburgh
Johnson, George M.	Richmond	Wayne-Union
Johnson, Herbert S.	Lafayette	Tippecanoe
Johnson, James B.	Greencastle	Putnam
Johnson, J. M.	Palmyra	Harrison-Crawford
Johnson, Lonnie B.	Gary	Lake
Johnson, Lowell R.	Lafayette	Tippecanoe
Johnson, M. H. C.	Vincennes	Knox
Johnson, Owen	Peru	Miami
Johnson, Paul D., Jr.	Huntington, W. Va.	Vigo
Johnson, Paul S.	Richmond	Wayne-Union
Johnson, R. B.	Rushville	Rush
Johnson, S. L.	Evansville	Vanderburgh
Johnson, Thomas W.	Indianapolis	Marion
Johnson, W. A.	Perrysville	Parke-Vermillion
Johnson, William A.	North Vernon	Jennings
Johnson, Wm. F.	Indianapolis	Marion
Johnston, Alan	Plainfield	Hendricks
Johnston, Richard M.	Fort Wayne	Allen
Johnston, Robert L.	Bluffton	Wells
Johnston, R. G.	Huntington	Huntington
Jolly, Lewis E.	Madison	Jefferson-Switzerland
Jones, Albert T.	Anderson	Madison
Jones, Allen W.	Indianapolis	Marion
Jones, Charles A.	Franklin	Marion
Jones, Clifford M.	Whiting	Lake
Jones, David	Lafayette	Tippecanoe
Jones, David E.	Indianapolis	Marion

Name	City	County	Name	City	County
Jones, E. S.	Hammond	Lake	Kennedy, Eva	Camden	Carroll
Jones, Francis P.	Indianapolis	Marion	Kennedy, Hall	Indianapolis	Marion
Jones, George	Wanamaker	Marion	Kennedy, H. F.	Indianapolis	Marion
Jones, H. E.	Anderson	Madison	Kennedy, R. O.	Rushville	Rush
Jones, John C.	LaPorte	LaPorte	Kennedy, W. U.	New Castle	Henry
Jones, John Carl	Logansport	Cass	Kenoyer, Wilbur L.	Indianapolis	Marion
Jones, King Solomon	Michigan City	LaPorte	Kent, J. A. (S)	Mulberry	Clinton
Jones, R. B.	LaPorte	LaPorte	Kent, Richard N.	Ft. Wayne	Allen
Jones, Roland W.	Indianapolis	Marion	Kenyon, C. E.	Cambridge City	Wayne-Union
Jones, W. W.	Frankfort	Clinton	Kenyon, Omar A.	Indianapolis	Marion
Jordan, Leo E.	Lynn	Randolph	Kephart, S. Bruce	Bluffton	Wells
Joseph, Rex M.	Indianapolis	Marion	Kepler, R. W.	La Porte	La Porte
Jurgensen, Walter T.	Ft. Wayne	Allen	Kercheval, John M.	Clinton	Parke- Vermillion
Justen, Jerome W.	Calumet City, Ill.	Lake			
K			Kern, C. B. (S)	Muncie	Delaware- Blackford
Kabel, Robert N.	Terre Haute	Vigo	Kern, C. G.	Lebanon	Boone
Kahan, H. L.	Tucson, Ariz.	Lake	Kerr, Donald M.	Bedford	Lawrence
Kahle, Dan B.	Indianapolis	Marion	Kerr, Harry R.	Indianapolis	Marion
Kahler, M. V.	Indianapolis	Marion	Kerrigan, John F.	Michigan City	LaPorte
Kahn, Alexander J.	Indianapolis	Marion	Kerrigan, R. L.	Michigan City	La Porte
Kahn, Howard L.	Indianapolis	Marion	Kerrigan, William F.	Rockport	Spencer
Kalb, Everett L.	Indianapolis	Marion	Keseric, Nicholas E.	French Lick	Orange
Kamen, Jack M.	East Chicago	Lake	Kessler, Robert B.	Evansville	Vanderburgh
Kamm, Bernard A.	South Bend	St. Joseph	Ketcham, Jane M.	Indianapolis	Marion
Kamman, G. H. (S)	Seymour	Jackson	Ketcham, John S.	Rossville	Clinton
Kammen, Leo	Indianapolis	Marion	Khaton, Odessa M.	Gary	Lake
Kammen, Robert	Indianapolis	Marion	Kidd, James G.	Roann	Wabash
Kammer, Grace C.	Muncie	Delaware- Blackford	Kidder, Orva T.	Ft. Wayne	Allen
Kammer, Walter F.	Muncie	Delaware- Blackford	Kiechle, Frederick L.	Biloxi, Miss.	Vanderburgh
Kantzer, Floyd B.	Garrett	De Kalb	Kilgore, Byron, Jr.	Indianapolis	Marion
Kaplan, Benjamin B.	Hammond	Lake	Killian, E. Camille	Logansport	Cass
Karberg, Richard J.	Lafayette	Tippecanoe	Killian, Edgar W.	Logansport	Cass
Karn, John W.	South Bend	St. Joseph	Kim, Young D.	Beech Grove	Marion
Karol, Herbert J.	Fort Wayne	Allen	Kimbrough, Robert F.	Fort Wayne	Allen
Karpel, Bernard	Mooreville	Morgan	Kime, Charles E.	Richmond	Wayne-Union
Karsell, W. A.	Bloomington	Owen- Monroe	Kime, E. N.	Indianapolis	Marion
Katterjohn, James C.	Indianapolis	Marion	Kime, J. T. (S)	Petersburg	Pike
Kauffman, Harley M.	Evansville	Vanderburgh	Kindell, H. D.	New Richmond	Montgomery
Kauffman, Nelson N.	Indianapolis	Marion	King, Dale	Fairmount	Grant
Kauffman, Sidney A.	Indianapolis	Marion	King, Everett A.	Washington, D. C.	Vanderburgh
Kaufman, Julian	Fort Wayne	Allen	King, Joseph W.	Anderson	Madison
Kay, Oran	Spencer	Owen- Monroe	King, P. C.	Swayzee	Grant
Keck, Carleton A.	Fort Wayne	Allen	King, Robert W.	Cedar Lake	Lake
Keeling, F. E.	Portland	Jay	King, William B.	Cedar Lake	Lake
Keeling, J. E. (S)	Waldron	Shelby	King, William E.	Indianapolis	Marion
Keenan, R. L.	Indianapolis	Marion	King, William F. (S)	Indianapolis	Marion
Keever, C. H.	Indianapolis	Marion	Kingsbury, J. K.	Indianapolis	Marion
Keezer, William S.	Vincennes	Knox	Kinnaman, H. A.	Crawfordsville	Montgomery
Keiser, V. D.	Indianapolis	Marion	Kinneman, R. E.	Greenfield	Hancock
Keith, F. E. (S)	St. Bernice	Parke- Vermillion	Kintner, Burton E.	Elkhart	Elkhart
Keller, Frank (S)	Alexandria	Madison	Kinzel, Robert J. W.	Indianapolis	Marion
Kelley, Clement E.	Indianapolis	Marion	Kinzie, M. Dale	Goshen	Elkhart
Kelly, Don E.	Indianapolis	Marion	Kirkhoff, Paul J.	Indianapolis	Marion
Kelly, Frank	Argos	Marshall	Kirklun, Oren L.	Indianapolis	Marion
Kelly, J. F.	Indianapolis	Marion	Kirshman, F. E.	Muncie	Delaware- Blackford
Kelly, W. C.	Anderson	Madison	Kirtley, J. M.	Crawfordsville	Montgomery
Kelly, W. R.	Goshen	Elkhart	Kirtley, William R.	Indianapolis	Marion
Kelly, Walter F. (S)	Indianapolis	Marion	Kiser, E. F.	Indianapolis	Marion
Kelly, William M.	Indianapolis	Marion	Kissinger, K. L.	Angola	Steuben
Kelsey, L. E.	Kewanna	Fulton	Kistler, James J.	La Porte	La Porte
Kelsey, Robert M.	LaPorte	La Porte	Kistner, Arthur W.	Elkhart	Elkhart
Kemp, John T.	Michigan City	La Porte	Kitterman, Harry E.	Indianapolis	Marion
Kemp, W. A.	Connersville	Fayette- Franklin	Klahr, Elsworth	South Bend	St. Joseph
Kemper, A. T. (S)	Muncie	Delaware- Blackford	Klain, B. V.	Indianapolis	Marion
Kempf, G. F.	Indianapolis	Marion	Klamer, Charles H.	Jasper	Dubois
Kendall, F. M.	Nappanee	Elkhart	Klatch, Ben Z.	Lafayette	Tippecanoe
Kendrick, Frank J.	Gary	Lake	Klaus, J. M.	Crown Point	Lake
Kendrick, W. M.	Indianapolis	Marion	Kleifgen, William A.	Fort Wayne	Allen
			Kleindorfer, R. L.	Evansville	Vanderburgh
			Kleinman, F. J.	Hebron	Porter

Name	City	County	Name	City	County
Klepinger, H. E.	Lafayette	Tippecanoe	Ladig, Donald S.	Fort Wayne	Allen
Kling, Victor F.	Michigan City	La Porte	LaDine, C. B.	Indianapolis	Marion
Klingler, Maurice O.	Plymouth	Marshall	LaDuron, Jules F.	Muncie	Delaware-Blackford
Knapp, Arthur L.	South Bend	St. Joseph	LaFollette, Forrest R.	Whiting	Lake
Kneidel, John H.	Frankfort	Clinton	LaFollette, Robert E.	New Albany	Floyd
Knepple, L. R. (S)	Kokomo	Howard	Lahr, Philip A.	Anderson	Madison
Knodel, Kenneth T.	South Bend	St. Joseph	Laird, L. A.	Richmond	Wayne-Union
Knotts, Slater	Rochester	Fulton	Lamb, E. B.	Indianapolis	Marion
Knowles, Charles Y.	Indianapolis	Marion	Lamb, J. Leonard	South Bend	St. Joseph
Knowles, Robert P.	Indianapolis	Marion	Lamb, Russell	Indianapolis	Marion
Knox, Edwin S.	Paoli	Orange	Lamber, C. K.	Indianapolis	Marion
Ko, Richard	Eaton	Delaware-Blackford	Lamey, James L.	Anderson	Madison
			Lamey, P. T.	Anderson	Madison
Kobrak, H. G.	Chicago, Ill.	Lake	Lancet, Robert O.	Terre Haute	Vigo
Kobrin, Meyer W.	Gary	Lake	Land, Francis L.	Fort Wayne	Allen
Koch, Elmer L.	Danville	Hendricks	Landis, Charles	Logansport	Cass
Koehler, Elmer G.	Elkhart	Elkhart	Lane, W. H. (S)	Angola	Steuben
Kohlstaedt, George	Indianapolis	Marion	Lane, Wm. H.	South Bend	St. Joseph
Kohlstaedt, Karl C.	Indianapolis	Marion	Lang, Joseph E.	South Bend	St. Joseph
Kohlstaedt, K. G.	Indianapolis	Marion	Lang, Shirley C.	Rockport	Spencer
Kohne, C. J.	Decatur	Adams	Langdon, H. K. (S)	Indianapolis	Marion
Kohrman, Benj. M.	Michigan City	La Porte	Langdon, J. Ray	Pueblo, Colo.	Marion
Kolanko, Leon A.	Hammond	Lake	Langenbahn, C. J.	South Bend	St. Joseph
Kolettis, George J.	Gary	Lake	Langohr, John	Columbia City	Whitley
Komoroske, J. E.	East Chicago	Lake	Langsdon, Fred	Gaston	Delaware-Blackford
Koons, Karl M.	Indianapolis	Marion			
Koontz, William A.	Gas City	Grant	Lanning, R. Adrian	Phoenix, Ariz.	Marion
Kopanko, Bernard F.	Huntington, W. Va.	Lake	Lansford, John	Redkey	Jay
			Laramore, Ward	Indianapolis	Marion
Kopcha, Joseph E.	Gary	Lake	Larkin, Bernard J.	Indianapolis	Marion
Kopecky, Robert R.	Indianapolis	Marion	Larmore, J. L.	Anderson	Madison
Kopp, Herschel S.	Santa Barbara, Calif.	Marion	Larmore, Sarah H.	Anderson	Madison
			LaRocca, Joseph	South Bend	St. Joseph
Kopp, O. A.	Anderson	Madison	Larrabee, James F.	Hammond	Lake
Koransky, David S.	Hammond	Lake	Larrabee, Wm. H. (S)	New Palestine	Hancock
Korn, Jerome M.	Gary	Lake	Larrison, G. D.	Morocco	Jasper-Newton
Kornafel, L. H.	Indianapolis	Marion			
Kraft, Bennett	Indianapolis	Marion	Larson, G. O.	La Porte	La Porte
Kraft, Haldon C.	Noblesville	Hamilton	Larson, John A.	Logansport	Cass
Kramer, A. A.	South Bend	St. Joseph	LaSalle, R. M.	Wabash	Wabash
Kraning, Kenneth	Kewanna	Fulton	Lashley, Donald L.	Tell City	Perry
Kratz, Paul E.	Columbia City	Whitley	Laubscher, Clarence	Evansville	Vanderburgh
Kresler, Leon	Rensselaer	Jasper-Newton	Laudeman, W. A.	Elwood	Madison
			Lauer, D. B.	Dana	Parke-Vermillion
Kretsch, R. W.	Hammond	Lake			
Kriebble, Wm. W.	Terre Haute	Vigo	Lautz, Herbert A.	Hammond	Lake
Krieger, George M.	Michigan City	La Porte	Lavengood, R. W.	Marion	Grant
Kriel, William B.	Indianapolis	Marion	Lawler, George F.	Indianapolis	Marion
Kring, Gerald G.	LaPorte	LaPorte	Lawrence, Edwin A.	Indianapolis	Marion
Kron, R. Vincent	East Gary	Lake	Lawrence, Joseph C.	Evansville	Vanderburgh
Krueger, Frederick W.	Richmond	Wayne-Union	Laws, H. J.	Lafayette	Tippecanoe
Krueger, John E.	South Bend	St. Joseph	Laws, Kenneth F.	Lafayette	Tippecanoe
Krueger, Robert B.	Indianapolis	Marion	Lawson, I. H.	Kendallville	Noble
Kruse, E. H.	Fort Wayne	Allen	Lazo, Vicente R.	Hammond	Lake
Kruse, Walter E.	Fort Wayne	Allen	Leak, Robert H.	Boswell	Benton
Kubik, Francis J.	Michigan City	La Porte	Leasure, J. K.	Indianapolis	Marion
Kubley, James D.	Plymouth	Marshall	Leasure, Kenneth	Elkhart	Elkhart
Kudele, L. T.	Whiting	Lake	Leatherman, H. L.	Indianapolis	Marion
Kuder, Howard V.	Muncie	Delaware-Blackford	Lebioda, Henry S.	Gary	Lake
			Lee, Glen Ward	Richmond	Wayne-Union
Kuhn, Frederick L.	South Bend	St. Joseph	Leedy, Gladys J.	Indianapolis	Marion
Kuhn, Hedwig S.	Hammond	Lake	Leff, Abe	Indianapolis	Marion
Kuhn, Hugh A.	Hammond	Lake	Leffel, James M.	Indianapolis	Marion
Kuhn, R. W.	Wilkinson	Hancock	Leffler, William T.	Indianapolis	Marion
Kunkler, Joseph	Terre Haute	Vigo	Lefforge, E. Everett	Veedersburg	Fountain-Warren
Kunkler, Wm. C.	Terre Haute	Vigo			
Kuntz, Herman W.	Indianapolis	Marion	Lehman, Harold	Berne	Adams
Kurtz, Fred B.	Indianapolis	Marion	Lehman, Kenneth M.	Topeka	LaGrange
Kurtz, Philip L.	Indianapolis	Marion	Lehmberg, O. F.	Columbia City	Whitley
Kurtz, William A.	Tipton	Marion	Lehner, John H.	Fort Wayne	Allen
Kwitny, I. J.	Indianapolis	Marion	Leich, Charles F.	Evansville	Vanderburgh
			Leinbach, Earl	Hamlet	Starke
			LeMaster, Theodore R.	Indianapolis	Marion
			Leming, Ben L.	Ft. Wayne	Allen
			Lemmon, Brandt E.	Cloverdale	Putnam

L

Name	City	County	Name	City	County
Lemon, Herbert K.	Logansport	Cass	Loving, J. B.	New Goshen	Vigo
Lenk, George G.	Fort Wayne	Allen	Luckett, Coen L.	Terre Haute	Vigo
Leonard, Henry S. (S)	Indianapolis	Marion	Luckey, H. A.	Wolf Lake	Noble
Leser, R. U.	Indianapolis	Marion	Luckey, R. C.	Wolf Lake	Noble
Lett, Emory B.	Loogootee	Daviess-Martin	Ludwig, Oscar D.	Indianapolis	Marion
Levering, Guy P. (S)	Lafayette	Tippecanoe	Luginbill, Howard M.	South Bend	St. Joseph
Levi, Leon	Indianapolis	Marion	Lukemeyer, Geo. T.	Jasper	Dubois
Levin, Eli	East Chicago	Lake	Lukemeyer, St. John	Jasper	Dubois
Levin, Ralph T.	Indianapolis	Marion	Lukemeyer, L. C. (S)	Huntingburg	Dubois
Lewis, George N.	Gary	Lake	Lukenbill, Emery D.	Indianapolis	Marion
Lewis, James F.	Liberty	Wayne-Union	Lundeberg, Ralph A.	Griffith	Lake
Lewis, Leonard D.	Peru	Miami	Lundt, Milo O.	Elkhart	Elkhart
Lewis, Marvin A.	Phila., Pa.	Lake	Lung, B. D.	Kokomo	Howard
Lewis, Robert J.	Lawrence	Marion	Lurie, Paul R.	Indianapolis	Marion
Libbert, Edwin L.	Indianapolis	Marion	LuRos, J. Theodore	Indianapolis	Marion
Libbert, Edwin, Jr.	Indianapolis	Marion	Lutes, D. L.	Butler	Jennings
Lichtenberg, Melvin	Indianapolis	Marion	Luthy, Karl R.	South Bend	St. Joseph
Lidikay, Edward C.	Indianapolis	Marion	Lutz, Georgianna	Gary	Lake
Life, Homer	New Castle	Henry	Luzadder, J. E. (S)	Bloomington	Owen-Monroe
Lindenberg, Paul G.	Indianapolis	Marion	Luzadder, J. E., Jr.	New Carlisle	St. Joseph
Lindsay, H. B.	Washington	Daviess-Martin	Lybrook, D. E.	Young America	Cass
Line, H. E.	Chili	Miami	Lybrook, William B.	Indianapolis	Marion
Ling, John F.	Richmond	Wayne-Union	Lynch, Harold D.	Evansville	Vanderburgh
Lingeman, Byron N.	Crawfordsville	Montgomery	Lynch, Otis R.	Marengo	Harrison-Crawford
Lingeman, Raleigh E.	Indianapolis	Marion	Lynn, F. M. (S)	Peru	Miami
Lingeman, Roger	Indianapolis	Marion	Lyon, Florence	Portland	Jay
Link, Goethe	Indianapolis	Marion	Lyon, William C.	Fort Wayne	Allen
Link, William C.	Bloomington	Owen-Monroe	Lyons, R. E., Jr.	Bloomington	Owen-Monroe
Linn, E. E.	La Porte	La Porte	M		
Linton, C. D.	Indianapolis	Marion	MacDonald, J. A. (S)	Interlaken, N.Y.	Marion
Linton, C. E. (S)	Medaryville	Pulaski	MacKenzie, Pierce	Evansville	Vanderburgh
Lionberger, John R.	South Bend	St. Joseph	MacLeod, Donald F.	Morocco	Jasper-Newton
Lippoldt, Charles L.	Batesville	Ripley	Macer, Clarence G.	Evansville	Vanderburgh
Lipsey, Alfred J.	Hammond	Lake	Machledt, J. H.	Whiteland	Johnson
Liss, Emanuel C.	South Bend	St. Joseph	Mackel, Frederick O.	Ft. Wayne	Allen
Little, John W. (S)	Indianapolis	Marion	Mackey, Harry S.	Indianapolis	Marion
Little, Wm. J.	Indianapolis	Marion	Mackey, John E.	Indianapolis	Marion
Littlefield, Paul A.	San Francisco, Calif.	Marion	Macy, George W.	Columbus	Bartholomew-Brown
Litzenberger, S. W.	Anderson	Madison	Mader, John H.	Richmond	Wayne-Union
Lloyd, Claude A.	Washington	Daviess-Martin	Madtson, A. Ricks	Indianapolis	Marion
Lochry, R. L.	Indianapolis	Marion	Magennis, H. L.	Indianapolis	Marion
Lockhart, Jack M.	Connersville	Fayette-Franklin	Mahaffy, John H.	Evansville	Vanderburgh
Lockhart, Philip B.	South Bend	St. Joseph	Mahoney, Charles L.	Terre Haute	Vigo
Loehr, W. M.	Waltham, Mass.	Marion	Mahuron, Boyd L.	Dayton, Ohio	Delaware-Blackford
Loewenstein, W. L.	Terre Haute	Vigo	Majsterek, S. L.	Gary	Lake
Logan, A. R. (S)	Petersburg	Pike	Makovsky, Theodore	Valparaiso	Porter
Logan, James Z.	Richmond	Wayne-Union	Malcolm, Russell	Richmond	Wayne-Union
Logan, Jesse R.	Evansville	Vanderburgh	Malmstone, F. A. (S)	Griffith	Lake
Logan, Richard S.	Elkhart	Elkhart	Malone, L. A.	Terre Haute	Vigo
Lohman, Robert M.	Fort Wayne	Allen	Malott, Fred	Converse	Miami
Lohoff, Lewis C.	Tell City	Perry	Malouf, S. D.	Peru	Miami
Lomax, Claude	Costa Mesa, Calif.	Marion	Manalan, Maurice M.	Indianapolis	Marion
Long, Max	Marion	Grant	Manifold, Harold M.	Fortville	Hancock
Long, Paul L.	Anderson	Madison	Manion, Marlow W.	Indianapolis	Marion
Long, William H.	Indianapolis	Marion	Manley, Chas. N.	Rising Sun	Dearborn-Ohio
Loomis, Charles H.	Richmond	Wayne-Union	Mann, Mortimer	Indianapolis	Marion
Loomis, N. S.	Indianapolis	Marion	Manning, George	Fort Wayne	Allen
Loop, Floyd A. (S)	Lafayette	Tippecanoe	Manning, Joseph C.	Midwest City, Okla.	Marion
Loop, Frederick A.	Lafayette	Tippecanoe	Manning, K. R.	Indianapolis	Marion
Lord, G. C.	Indianapolis	Lore	Manuel, Donald	Edinburg	Johnson
Lorenty, T. B.	Gary	Lake	Manzie, Michael	Indianapolis	Marion
Lorman, James G.	Fort Wayne	Allen	Maple, J. B.	Sullivan	Sullivan
Loudermilk, J. L.	Ft. Wayne	Allen	Marchand, Austin F.	Haubstadt	Gibson
Love, George N.	Indianapolis	Marion	Marchand, Edwin V.	Haubstadt	Gibson
Love, V. Logan	Marion	Grant	Marchant, Clarence H.	Bloomington	Owen-Monroe
Lovell, Martin H.	Gary	Lake	Marcus, Emanuel	Hammond	Lake
Lovett, H. D.	Whitestown	Boone			

Name	City	County	Name	City	County
Marcus, M. C.	Gary	Lake	McCarthy, Jeremiah A.	Whiting	Lake
Maris, Lee J.	Attica	Fountain- Warren	McCartney, Donald H.	Indianapolis	Marion
Markel, I. J.	Elkhart	Elkhart	McCarty, Virgil	Princeton	Gibson
Markey, R. J. P.	Hammond	Lake	McCaskey, C. H.	Indianapolis	Marion
Markle, Joseph G.	Hammond	Lake	McClain Edwin S.	Indianapolis	Marion
Marks, H. H.	Huntington	Huntington	McClain, Marvin	Scottsburg	Scott
Marks, Maurice I.	Indianapolis	Marion	McClellan, John B.	Muncie	Delaware- Blackford
Marks, Ora L.	East Chicago	Lake	McClelland, D. C.	Lafayette	Tippecanoe
Marks, Salvo P.	Hammond	Lake	McClelland, Harry N.	Alexandria	Madison
Marr, Griffith	Columbus	Bartholomew- Brown	McClintock, James A.	Muncie	Delaware- Blackford
Marsh, Chester A.	Hagerstown	Henry	McClure, Clark	Knox	Starke
Marsh, George W.	Lafayette	Tippecanoe	McClure, S. E.	Monon	White
Marsh, William L.	Lafayette	Tippecanoe	McConnell, Wm. C.	Sunman	Ripley
Marshall, Albert L., Jr.	Indianapolis	Marion	McCool, J. H.	Evansville	Vanderburgh
Marshall, C. R.	Indianapolis	Marion	McCool, W. E. (S)	Evansville	Vanderburgh
Marshall, George L.	Bourbon	Marshall	McCord, C. B.	Veedsburg	Fountain- Warren
Marshall, Lloyd C.	Mt. Summit	Henry	McCormick, C. O., Jr.	Indianapolis	Marion
Marshall, Millard R.	Gary	Lake	McCormick, C. O., Sr.	Indianapolis	Marion
Martin, C. E.	Lynn	Randolph	McCormick, H. D.	Vincennes	Knox
Martin, Charles F.	Mishawaka	St. Joseph	McCormick, W. C.	Terre Haute	Vigo
Martin, Floyd S.	Goshen	Elkhart	McCown, P. E.	Indianapolis	Marion
Martin, Guy	Seymour	Jackson	McCoy, George E.	Muncie	Delaware- Blackford
Martin, Harold G.	Lafayette	Tippecanoe	McCoy, Roy R.	Ft. Wayne	Allen
Martin, Hugh E.	Indianapolis	Marion	McCracken, J. O.	Montgomery	Daviess- Martin
Martin, Loren H.	Indianapolis	Marion	McCraley, William J.	South Bend	St. Joseph
Martin, W. B.	La Porte	La Porte	McCrea, Fred R.	Terre Haute	Vigo
Martz, Bill L.	Indianapolis	Marion	McCullough, Henry G.	Columbus	Bartholomew- Brown
Martz, Carl D.	Indianapolis	Marion	McCullough, J. Y.	New Albany	Floyd
Marvel, Robert J.	Indianapolis	Marion	McDaniel, F. P.	Atlanta	Hamilton
Maschmeyer, R. H.	Shoals	Daviess- Martin	McDevitt, D. R.	Indianapolis	Marion
Mason, Bernard	South Bend	St. Joseph	McDonald, Frank C.	New Castle	Henry
Mason, Donald G.	Angola	Steuben	McDonald, J. D.	Evansville	Vanderburgh
Mason, Everett E.	Evansville	Vanderburgh	McDonald, R. M.	South Bend	St. Joseph
Mason, Lester M.	Terre Haute	Vigo	McDonald, V. G.	Anderson	Madison
Mason, Richard L.	Hammond	Lake	McDowell, Fletcher W.	Muncie	Delaware- Blackford
Masters, John M.	Indianapolis	Marion	McDowell, George A.	Ft. Wayne	Allen
Masters, R. J.	Indianapolis	Marion	McDowell, M. M.	Vincennes	Knox
Mather, Robert	San Antonio, Texas	Marion	McEachern, Cecil	Ft. Wayne	Allen
Mather, J. W.	East Gary	Lake	McElroy, J. S.	New Castle	Henry
Mathews, W. C.	Kentland	Jasper- Newton	McElroy, R. S.	Princeton	Gibson
Mathys, Alfred	Mauckport	Harrison- Crawford	McEwen, J. W.	Terre Haute	Vigo
Matteucci, Walter V.	Wabash	Wabash	McFadden, James M.	Lafayette	Tippecanoe
Matthew, John R.	North Judson	Starke	McFall, J. R. S.	Ft. Wayne	Allen
Matthew, W. B.	Indianapolis	Marion	McFarland, Corley B.	South Bend	St. Joseph
Matthews, B. J.	Indianapolis	Marion	McGilvray, Eva R. T.	Rockville	Parke- Vermillion
Matthews, Chas. B. (S)	Hammond	Lake	McGrath, Michael F.	Indianapolis	Marion
Matthews, D. W.	North Vernon	Jennings	McGue, Frank T.	Indianapolis	Marion
Matthews, William M.	Indianapolis	Marion	McGuff, Paul	Indianapolis	Marion
Mattmiller, Everette D.	Avilla	Noble	McGuire, D. F.	East Chicago	Lake
Mattox, Don M.	Terre Haute	Vigo	McIlwain, Eleanor	Marion	Grant
Matychowiak, Francis	Knightstown	Henry	McIlwain, Robert	Marion	Grant
Maurer, J. F.	Brazil	Clay	McIndoo, R. E.	Kokomo	Howard
Maurer, Robert M.	Brazil	Clay	McIntire, Clarence R.	Indianapolis	Marion
Maxson, Roy V.	Anderson	Madison	McIntosh, Wilbert	Riley	Vigo
Maxwell, J. B. (S)	Logansport	Cass	McIntyre, Charles J. (S)	Indianapolis	Marion
May, George A.	Madison	Jefferson- Switzerland	McIntyre, J. M.	Indianapolis	Marion
May, R. Milton.	Gary	Lake	McKay, Robert	LaFontaine	Wabash
Mayfield, C. H. (S)	Reynolds	White	McKechnie, Franklin B.	Watervliet, N. Y.	Marion
McAdams, Hugh B.	Lafayette	Tippecanoe	McKee, Horace N. (S)	Elkhart	Elkhart
McAdams, Robert	Lafayette	Tippecanoe	McKee, H. S. (S)	Greensburg	Decatur
McArdle, Edward G.	Ft. Wayne	Allen	McKeeman, D. H.	Ft. Wayne	Allen
McArt, Bruce A.	Elkhart	Elkhart	McKeeman, L. S.	Ft. Wayne	Allen
McAtee, Otto B.	Madison	Jefferson- Switzerland	McKenna, H. J.	South Bend	St. Joseph
McBride, James S.	Indianapolis	Marion	McKinley, A. D.	Indianapolis	Marion
McBride, Noel S.	Terre Haute	Vigo	McKinley, Joseph	Lafayette	Tippecanoe
McCabe, James E. (S)	Otterbein	Benton	McKinney, D. H.	Lafayette	Tippecanoe
McCallister, John W.	Ft. Wayne	Allen	McKinstry, Homer	Indianapolis	Marion
McCallum, J. T. C.	Indianapolis	Marion			
McCarthy, Daniel J. (S)	Indianapolis	Marion			

Name	City	County	Name	City	County
McKittrick, Jack	Washington	Daviess-Martin	Miller, D. B. (S)	Terre Haute	Vigo
McKnight, Robert D.	Camp Atterbury	Bartholomew-Brown	Miller, E. H.	Valparaiso	Porter
McLaughlin, C. P.	Pendleton	Madison	Miller, Frank	Morristown	Shelby
McLaughlin, G. C.	Terre Haute	Vigo	Miller, Galen R.	Elkhart	Elkhart
McLaughlin, James R.	Flora	Carroll	Miller, H. Allison	Marion	Grant
McLean, James S.	Hammond	Lake	Miller, H. L. (S)	West Baden	Orange
McLelland, Mary R.	Bloomington	Owen-Monroe	Miller, Harold E.	Seymour	Jackson
McMahan, Virgil	Vincennes	Knox	Miller, H. Paul	Ft. Wayne	Allen
McMichael, F. J.	Gary	Lake	Miller, Hugh A.	Elkhart	Elkhart
McMichael, R. M.	Muncie	Delaware-Blackford	Miller, J. Don	Indianapolis	Marion
McMillan, F. G.	Indianapolis	Marion	Miller, James C.	Greensburg	Decatur
McNabb, G. B.	Carthage	Rush	Miller, Joseph A.	Cumberland	Marion
McNairy, Donald J.	Ft. Wayne	Allen	Miller, LaVerne B.	Evansville	Vanderburgh
McNamara, John P.	Indianapolis	Marion	Miller, M. E.	Goshen	Elkhart
McNaughton, L. M.	Washington	Daviess-Martin	Miller, Mahlon F.	Ft. Wayne	Allen
McNeely, M. J.	Dillsboro	Dearborn-Ohio	Miller, Mary E.	Bloomington	Owen-Monroe
McQuiston, R. J.	Indianapolis	Marion	Miller, Milton	Evansville	Vanderburgh
McTurnan, Robert W.	Indianapolis	Marion	Miller, Milo	South Bend	St. Joseph
McVey, Clarence A.	Hammond	Lake	Miller, Minor	Evansville	Vanderburgh
McWilliams, W. B.	Liberty	Wayne-Union	Miller, Orval J.	Ft. Wayne	Allen
Mead, C. H.	Bluffton	Wells	Miller, R. S.	Indianapolis	Marion
Meade, Walter W.	Bicknell	Knox	Miller, Ray D.	Martinsville	Morgan
Meador, Eric B.	Indianapolis	Marion	Miller, Richard C.	Shelbyville	Shelby
Medcalf, Norman L.	Lamar	Spencer	Miller, Richard H.	Ft. Wayne	Allen
Megenhardt, D. S.	Indianapolis	Marion	Miller, Robert J.	Evansville	Vanderburgh
Mehl, Rudolph A.	Evansville	Vanderburgh	Miller, Roland E.	Lafayette	Tippecanoe
Meikle, Louise J.	W. Lafayette	Tippecanoe	Miller, S. J.	W. Lafayette	Tippecanoe
Meiks, Lyman T.	Indianapolis	Marion	Miller, S. T.	Elkhart	Elkhart
Meiner, J. A.	Kokomo	Howard	Miller, Virgil	Akron	Fulton
Meiser, Robert	Huntington	Huntington	Miller, Wallace	Indianapolis	Marion
Meister, Doris (S)	Anderson	Madison	Miller, Wm. A.	Hagerstown	Henry
Melloh, A. F.	Indianapolis	Marion	Milleson, Ann L. M.	Terre Haute	Vigo
Mendelson, Stanley M.	Indianapolis	Marion	Millikan, William	Indianapolis	Marion
Mendenhall, Clarence D.	Indianapolis	Marion	Mills, Fred E.	Evansville	Vanderburgh
Mendenhall, Edgar	Ft. Wayne	Allen	Mills, J. F.	Wabash	Wabash
Mendez, Carlos	Elkhart	Elkhart	Milne, Walter S.	Michigan City	LaPorte
Mensch, James R.	Fort Wayne	Allen	Minczewski, Richard C.	Gary	Lake
Mentendiek, M. H.	Indianapolis	Marion	Minick, Linus	Churubusco	Whitley
Mercer, Arthur H.	Gary	Lake	Mininger, Edward P.	Elkhart	Elkhart
Mercer, Samuel R.	Ft. Wayne	Allen	Mino, Raymond W.	Evansville	Vanderburgh
Merchant, Raymond	Crown Point	Lake	Mino, Robert A.	Evansville	Vanderburgh
Meredith, E. J.	Richmond	Wayne-Union	Mintz, Alfred M.	Marion	Grant
Mericle, Earl W.	Indianapolis	Marion	Mirro, John A.	Lowell	Lake
Merrell, B. M.	Rockville	Parke-Vermillion	Misch, William	Cedar Lake	Lake
Merrell, Paul	Indianapolis	Marion	Mishkin, Irving	Elkhart	Elkhart
Mertz, H. O.	Indianapolis	Marion	Mitchell, Albert M.	Terre Haute	Vigo
Mertz, John H. O.	Indianapolis	Marion	Mitchell, E. T.	Romney	Tippecanoe
Messer, F. W.	Kendallville	Noble	Mitchell, Earl H.	Indianapolis	Marion
Metcalf, George B.	Anderson	Madison	Mitchell, Edward O.	Indianapolis	Marion
Metcalfe, G. E.	South Bend	St. Joseph	Mitchell, G. L.	Smithville	Owen-Monroe
Mettler, Don C.	Ann Arbor, Mich.	De Kalb	Mitchell, George S.	Bluffton	Wells
Meyer, Herman A.	Ft. Wayne	Allen	Mitchell, R. E.	Springfield, Missouri	Marion
Meyer, K. T.	Evansville	Vanderburgh	Mitman, F. B.	Huntington	Huntington
Meyer, Milo G.	Michigan City	La Porte	Moats, C. F.	Ft. Wayne	Allen
Meyer, Orlando L.	Bedford	Lawrence	Moats, G. E.	Ft. Wayne	Allen
Meyer, R. C.	Vincennes	Knox	Modisett, Jackson W.	Madison	Jefferson-Switzerland
Meyer, Theodore O.	Ft. Wayne	Allen	Modisett, Marcella S.	Madison	Jefferson-Switzerland
Meyn, Werner P.	Terre Haute	Vigo	Modjeska, Gerald S.	Indianapolis	Marion
Michaelis, S. C.	Ft. Wayne	Allen	Modjeski, Joseph R.	Hammond	Lake
Michaels, Joseph F. (S)	Edinburg	Johnson	Modjeski, Raymond J.	Hammond	Lake
Micheli, A. J.	Indianapolis	Marion	Moehlenkamp, C. E.	Evansville	Vanderburgh
Middleton, H. N.	Indianapolis	Marion	Moeller, Victor C.	Fort Wayne	Allen
Middleton, Thomas O.	Bloomington	Owen-Monroe	Moenning, W. P.	Indianapolis	Marion
Mikesch, W. H.	South Bend	St. Joseph	Molenda, Robert V.	Michigan City	LaPorte
Miklozek, John E.	Terre Haute	Vigo	Molengraft, C. J.	Gary	Lake
Miley, Weir M.	Anderson	Madison	Molloy, W. J. (S)	Muncie	Delaware-Blackford
Miller, Carl G.	Ft. Wayne	Allen	Molt, W. F. (S)	Indianapolis	Marion
Miller, Charles A. (S)	Princeton	Gibson	Monroe, F. Bruce	Crown Point	Lake
			Montgomery, L. G.	Muncie	Delaware-Blackford

Name	City	County	Name	City	County
Montgomery, S. B. (S)	Cynthiana	Posey	Murphy, Joseph F., Jr.	Hammond	Lake
Montgomery, Wm. F.	Indianapolis	Marion	Murphy, Josephine	South Bend	St. Joseph
Moon, Charles E.	Centerpoint	Clay	Murphy, M. G.	Morgantown	Morgan
Moore, B. B.	Indianapolis	Marion	Murray, Ernest C.	Kokomo	Howard
Moore, Edwin G.	Gary	Lake	Murray, Jas. S., Jr.	Beverly Hills, Calif.	Marion
Moore, E. Gregory	Gary	Lake	Musacchio, Frederick A.	Hammond	Lake
Moore, H. T.	Indianapolis	Marion	Musselman, G. G.	Terre Haute	Vigo
Moore, R. G.	Vincennes	Knox	Myers, Charles W.	Indianapolis	Marion
Moore, Thomas C.	Indianapolis	Delaware-Blackford	Myers, R. V.	Indianapolis	Marion
Moore, W. C.	Muncie	Delaware-Blackford	Myers, Wm. C.	Dana	Parke-Vermillion
Moosey, Louis	Union Mills	LaPorte	N		
Moran, Mark M.	Portland	Jay	Nabbe, Philip M.	Camp Atterbury	Bartholomew-Brown
Moran, Noel D.	Versailles	Ripley	Nafe, C. A.	Indianapolis	Marion
Moravec, Arthur E.	Ft. Wayne	Allen	Nagan, Robert F.	Indianapolis	Marion
Morchan, Samuel	Indianapolis	Marion	Nahrwold, Elmer W.	Ft. Wayne	Allen
Morec, George J.	Smoky Hill A.F.B., Kans.	Marion	Nakadate, Katsumi J.	Hammond	Lake
Morgan, Margaret E.	Indianapolis	Marion	Nance, W. K.	Vincennes	Knox
Morgan, S. P.	LaPorte	LaPorte	Napper, Floyd	Scottsburg	Scott
Moriarty, John R.	Indianapolis	Marion	Nash, Charles B.	Valparaiso	Porter
Morrical, Russell J.	Logansport	Cass	Nash, Justin R.	Albion	Noble
Morris, Hyman	Gary	Lake	Nason, R. A.	Garrett	DeKalb
Morris, J. W.	Muncie	Delaware-Blackford	Nassef, George	Walkerton	St. Joseph
Morris, Robert A.	Anderson	Madison	Nave, H. E.	Fountaintown	Shelby
Morris, Warren V.	Monticello	White	Navin, Hugh K.	Fortville	Hancock
Morris, W. F. (S)	Princeton	Gibson	Nay, E. O.	Terre Haute	Vigo
Morrison, John S. (S)	Lafayette	Tippecanoe	Nay, Richard M.	Indianapolis	Marion
Morrison, J. T.	Greensburg	Decatur	Neal, Leonard W.	Hammond	Marion
Morrison, Lindsey (S)	Hammond	Lake	Neale, Alfred E.	Anderson	Madison
Morrison, Lewis E. II	Indianapolis	Marion	Need, Louis T.	Indianapolis	Marion
Morrison, W. R.	Kokomo	Howard	Neely, A. S.	New Middletown	Harrison-Crawford
Morrow, George W.	Logansport	Cass	Neidballa, E. G.	Bristol	Elkhart
Mortenson, L. J.	Ft. Wayne	Allen	Neier, O. C. (S)	Indianapolis	Marion
Morton, Walter P.	Indianapolis	Marion	Neifert, Noel	Tell City	Perry
Moser, E. B. (S)	Windfall	Tipton	Nelson, Carl A.	West Lebanon	Fountain-Warren
Moser, Edward (S)	Woodburn	Allen	Nelson, F. Dale	South Bend	St. Joseph
Moser, R. H.	Indianapolis	Marion	Nelson, Harold E.	Muncie	Delaware-Blackford
Moses, George E.	Worthington	Greene	Nelson, Paul Leon	Anderson	Madison
Moses, Robert E.	Worthington	Greene	Nelson, Raymond	South Bend	St. Joseph
Mosier, Jack M.	Indianapolis	Marion	Nelson, Walfred A.	Gary	Lake
Moss, Bobby L.	Indianapolis	Marion	Nenneker, Henry (S)	Evansville	Vanderburgh
Moss, Harlan B.	Indianapolis	Marion	Nesbit, L. L.	Anderson	Madison
Moss, Herschel C.	Indianapolis	Marion	Nester, Henry G.	Indianapolis	Marion
Moss, M. J.	Yorktown	Delaware-Blackford	Netherton, C. R.	Chalmers	White
Moswin, Jack A.	Gary	Lake	Neucks, Howard C.	North Vernon	Jennings
Mothersill, M. H.	Indianapolis	Marion	Neudorff, Louis G.	Terre Haute	Vigo
Mott, C. A.	South Bend	St. Joseph	Neukamp, Frank H.	Connersville	Fayette-Franklin
Moulton, Lillian	Indianapolis	Marion	Neumann, K. O.	Lafayette	Tippecanoe
Mount, M. S.	Bloomfield	Greene	Neuwalt, Frank	Gary	Lake
Mount, Wm. M.	Crawfordsville	Montgomery	Newby, A. C.	Sheridan	Hamilton
Mountain, Francis	Connersville	Fayette-Franklin	Newby, Eugene	Sheridan	Hamilton
Muelchi, Adeline F.	Evansville	Vanderburgh	Newcomb, Wm. K.	Royal Center	Cass
Mueller, Hilbert M.	South Bend	St. Joseph	Newcomber, Frank V.	Elwood	Madison
Mueller, Lawrence W.	Ft. Wayne	Allen	Newland, A. E.	Bedford	Lawrence
Mueller, Lillian B.	Indianapolis	Marion	Newman, A. E.	Evansville	Vanderburgh
Muhleman, C. E.	LaPorte	LaPorte	Newnum, Raymond L.	Hagerstown	Wayne-Union
Mull, P. L. (S)	Louisville, Ky.	Washington	Nichols, Anne Sackett	Greencastle	Putnam
Muller, Lullus P.	Indianapolis	Marion	Nichols, Wm. E. (S)	Hammond	Lake
Muller, Paul F.	Indianapolis	Marion	Nichols, Wm. G., Jr.	Philadelphia, Pa.	Jefferson-Switzerland
Muller, Victor H.	Indianapolis	Marion	Nickel, Allen C.	Bluffton	Wells
Mumford, E. B.	Indianapolis	Marion	Nicosia, J. B.	East Chicago	Lake
Munk, C. E.	Kendallville	Noble	Nie, Grover	Huntington	Huntington
Murdock, H. L.	Ft. Wayne	Allen	Nie, Louis W.	Indianapolis	Marion
Murphy, E. C.	South Bend	St. Joseph	Niedermayer, Alfred	Evansville	Vanderburgh
Murphy, E. W.	New Albany	Floyd	Nielsen, Juul C.	Indianapolis	Marion
Murphy, Edward U.	Evansville	Vanderburgh	Nigh, R. M.	Fairland	Shelby
Murphy, Harold O.	Warsaw	Kosciusko	Nill, John H.	Ft. Wayne	Allen
Murphy, Harry	Franklin	Johnson			

Name	City	County	Name	City	County
Pettijohn, F. L. (S)	Indianapolis	Marion	Priebe, Fred H.	Hillsboro	Fountain-Warren
Petway, Allen P.	Madison	Jefferson-Switzerland	Proudfit, Charles H.	South Bend	St. Joseph
Peyton, Frank W.	Lafayette	Tippecanoe	Province, O. A. (S)	Franklin	Johnson
Pfaff, Dudley	Indianapolis	Marion	Province, William D.	Franklin	Johnson
Pfeifer, James M.	Lawrenceburg	Dearborn-Ohio	Pryor, R. C.	Indianapolis	Marion
Phares, Robert W.	Kokomo	Howard	Przednowek, A. C.	LaPorte	LaPorte
Phelps, Stephen R.	South Bend	St. Joseph	Pugh, Willis L.	Evansville	Vanderburgh
Phillips, David L.	Indianapolis	Marion	Pullman, George R.	Warsaw	Kosciusko
Phillips, John F.	Ft. Wayne	Allen	Pulskamp, B. H.	Wolcottville	Noble
Phillips, William R. (S)	Glenwood	Fayette-Franklin	Purcell, Jack H.	Boonville	Warrick
Phipps, Leland K.	Union City	Randolph	Purcell, Richard J.	Griffith	Lake
Piazza, Leonard F.	Michigan City	LaPorte	Puterbaugh, K. E.	Albany	Delaware-Blackford
Pickett, Paul	Clinton	Parke-Vermillion	Pyle, Harold D.	South Bend	St. Joseph
Pickett, Merle E.	Fort Wayne	Allen	Q		
Pickett, Robert D.	Indianapolis	Marion	Quarles, E. Bryan	Bloomington	Owen-Monroe
Pierce, Gene Stratton	New Albany	Floyd	Quick, Wm. J.	Muncie	Delaware-Blackford
Pierce, H. J.	Terre Haute	Vigo	Quickel, Daniel S. (S)	Anderson	Madison
Pierce, Wm. J.	Indianapolis	Marion	Quigley, Joseph B.	Indianapolis	Marion
Pierson, P. R.	New Albany	Floyd	R		
Pierson, Robert H.	Crawfordsville	Montgomery	Rabb, Frank M.	Indianapolis	Marion
Pierson, Thomas A.	New Palestine	Hancock	Rabb, Harry	Indianapolis	Marion
Pietz, David G.	Indianapolis	Marion	Raber, Robert M.	San Diego, Calif.	Marion
Pike, Warren H.	Hobart	Lake	Rabson, S. Milton	Ft. Wayne	Allen
Pilcher, Jack	Indianapolis	Marion	Rader, George S.	Indianapolis	Marion
Pilecki, Peter J.	Michigan City	LaPorte	Radigan, Leo R.	Indianapolis	Marion
Pilot, Jean	Hammond	Lake	Rainey, E. A. (S)	Lebanon	Boone
Pippenger, W. G.	Brook	Jasper-Newton	Ralston, John D.	Indianapolis	Marion
Pirkle, H. B.	Rockville	Parke-Vermillion	Ramage, W. F.	Beech Grove	Marion
Pitkin, Edward M.	Martinsville	Morgan	Ramey, John W.	Kokomo	Howard
Pitkin, M. C.	Martinsville	Morgan	Ramker, Daniel T.	East Chicago	Lake
Pizzo, Anthony	Bloomington	Owen-Monroe	Ramsdell, Glen A.	Richmond	Wayne-Union
Plain, George	South Bend	St. Joseph	Ramsey, Frank B.	Indianapolis	Marion
Plank, C. Robert	Michigan City	LaPorte	Ramsey, H. S.	Bloomington	Owen-Monroe
Plautz, Geraldine Z.	Indianapolis	Marion	Raney, B. B.	Linton	Greene
Ploetner, Edward J.	Jasper	Dubois	Rang, A. A.	Washington	Daviess-Martin
Ploughe, R. R.	Elwood	Madison	Rang, Robert H.	Washington	Daviess-Martin
Polhemus, Gretchen I.	New Albany	Floyd	Ranke, John W. H. (S)	Ft. Wayne	Allen
Polhemus, Warren C.	Anderson	Madison	Raphael, Isidor J.	Evansville	Vanderburgh
Pollak, Lewis	Indianapolis	Marion	Rasmussen, Ruth F.	South Bend	St. Joseph
Pollard, Walter	Evansville	Vanderburgh	Ratcliff, Frank W.	Lafayette	Tippecanoe
Pomeroy, Rex K.	Plymouth	Marshall	Ratcliffe, A. W.	Evansville	Vanderburgh
Poncher, Henry G.	Valparaiso	Porter	Rausch, Norman W.	Angola	Steuben
Ponczek, Edward	Fort Wayne	Allen	Ravdin, Bernard	Evansville	Vanderburgh
Pontius, Edwin E.	Fort Wayne	Allen	Rawles, Lyman T.	Ft. Wayne	Allen
Poolitson, Geo. C.	Bloomington	Owen-Monroe	Rawlins, Carolyn M.	Hammond	Lake
Popplewell, Arvine G.	Indianapolis	Marion	Ray, Herbert A. (S)	Ft. Wayne	Allen
Porro, Francis W.	Evansville	Vanderburgh	Raymond, Louis F.	Decatur	Adams
Porter, Carl M.	Jasonville	Greene	Reck, J. L.	Sheridan	Hamilton
Porter, Dale	Indianapolis	Marion	Records, A. W.	Franklin	Johnson
Porter, George C. (S)	Linton	Greene	Reed, Barbara Anne	Indianapolis	Marion
Porter, Jack	Lebanon	Boone	Reed, J. V. (S)	Indianapolis	Marion
Portteus, Walter L.	Franklin	Johnson	Reed, John J.	Hobart	Lake
Poston, C. L.	Laurel	Fayette-Franklin	Reed, Nelle C.	Michigan City	LaPorte
Potter, Brian	Kingsbury	LaPorte	Reed, Philip B.	Indianapolis	Marion
Potter, Richard M.	Ridgeville	Randolph	Reed, Robert C.	Terre Haute	Vigo
Potter, Thomas F., Jr.	South Bend	St. Joseph	Reed, Robert G., Jr.	Plymouth	Marshall
Powell, Edgar H.	Valparaiso	Porter	Reed, R. R.	Anderson	Madison
Powell, J. Paxton	Marion	Grant	Reed, Wm. C.	Bloomington	Owen-Monroe
Prather, Philip E.	Indianapolis	Marion	Reeder, Henry H.	Jeffersonville	Clark
Premuda, F. E.	Hammond	Lake	Rees, Russell C.	Indianapolis	Marion
Prenatt, Francis	Madison	Jefferson-Switzerland	Reese, Lawrence W.	South Bend	St. Joseph
Prentiss, Nelson M.	Ft. Wayne	Allen	Regan, George L.	Sellersburg	Clark
Present, Julian	Evansville	Vanderburgh	Reich, Clarence E.	Evansville	Vanderburgh
Price, Douglas W.	Nappanee	Elkhart	Reid, Chas. A.	Indianapolis	Marion
Price, Francis W.	Indianapolis	Marion	Reid, Robert M.	Columbus	Bartholomew-Brown
Price, James O.	Indianapolis	Marion			
Price, Shirley G.	Evansville	Vanderburgh			

Name	City	County	Name	City	County
Reid, Robert W.	Union City	Randolph	Robison, J. S.	Winchester	Randolph
Reilly, James F.	Vincennes	Knox	Robrock, Lawrence M.	Michigan City	LaPorte
Reisler, Simon	Indianapolis	Marion	Roby, A. L.	Jeffersonville	Clark
Reitz, Thomas F.	Evansville	Vanderburgh	Rockey, Noah A.	Ft. Wayne	Allen
Remich, A. C.	Hammond	Lake	Rodenbeck, Frank	Arcadia	Hamilton
Renbarger, L. L.	Marion	Grant	Rodin, Herman H.	South Bend	St. Joseph
Rendel, D. T.	Hammond	Lake	Rodriguez, Juan	Ft. Wayne	Allen
Rendel, H. E.	Mexico	Miami	Roesch, Ryland	Warsaw	Kosciusko
Reppert, Roland L.	Decatur	Adams	Rogers, Donald L.	Indianapolis	Marion
Rettig, A. C.	Muncie	Delaware- Blackford	Rogers, Evered E.	Auburn	DeKalb
Reynolds, D. M. (S)	Garrett	DeKalb	Rogers, Joseph G.	Lafayette	Tippecanoe
Reynolds, J. S.	Gary	Lake	Rogers, O. F.	Bloomington	Owen-Monroe
Reynolds, R. P.	Garrett	DeKalb	Rogers, Thomas P.	Philadelphia, Pa.	Marion
Reynolds, Richard J.	Terre Haute	Vigo	Rohn, Robert J.	Indianapolis	Marion
Rhamy, A. P.	Wabash	Wabash	Rohr, Joseph H.	Elkhart	Elkhart
Rhea, G. D.	Greencastle	Putnam	Rohrer, J. R.	Elnora	Daviess- Martin
Rhea, James C.	Beech Grove	Marion	Roller, C. W.	Indianapolis	Marion
Rhind, A. W.	Hammond	Lake	Rollins, Thomas K.	Bloomington	Owen- Monroe
Rhodes, A. H. (S)	Princeton	Gibson	Romberger, Floyd T.	W. Lafayette	Tippecanoe
Rhodes, Theodore D.	Indianapolis	Marion	Romberger, Floyd T., Jr.	Indianapolis	Marion
Rhorer, H. M.	Kokomo	Howard	Rommel, Clarence H.	W. Lafayette	Tippecanoe
Rhorer, John G.	Marion	Grant	Roose, Lisle W.	Nappanee	Elkhart
Rice, Frederic A.	Roswell, N. Mex.	Marion	Ropp, Eldon R.	Oakland City	Gibson
Rice, Raymond M.	Indianapolis	Marion	Ropp, H. E.	New Harmony	Posey
Rice, W. B.	Ft. Wayne	Allen	Rosenak, Bernard D.	Indianapolis	Marion
Richard, Norman F.	Shelbyville	Shelby	Rosenbaum, David	Indianapolis	Marion
Richards, D. H. (S)	Vincennes	Knox	Rosenbaum, Irving, Jr.	Indianapolis	Marion
Richards, E. E.	Russellville	Putnam	Rosenbaum, L. E.	Anderson	Madison
Richardson, C. L.	Rochester	Fulton	Rosenblatt, B. B.	Evansville	Vanderburgh
Richardson, Thad T.	Indianapolis	Marion	Rosenbloom, P. J.	Gary	Lake
Richart, J. V.	Terre Haute	Vigo	Rosenheimer, Geo. M.	South Bend	St. Joseph
Richer, O. H.	Warsaw	Kosciusko	Rosenthal, Carl	Hammond	Lake
Richter, Arthur B.	Indianapolis	Marion	Rosenwasser, Jacob	Mishawaka	St. Joseph
Richter, John C.	LaPorte	LaPorte	Roser, A. J.	Ft. Wayne	Allen
Richter, Samuel	New Orleans, La.	Lake	Rosevear, Henry J.	Hammond	Lake
Ricketts, J. W.	Indianapolis	Marion	Ross, Alexander T.	Indianapolis	Marion
Ridgeway, O. W.	Indianapolis	Marion	Ross, Ben R.	Bloomington	Owen-Monroe
Ridgway, Alton H.	Lapel	Madison	Ross, Guy E.	Anderson	Madison
Rieger, I. Taylor	Bloomington	Owen-Monroe	Ross, Harry P.	Richmond	Wayne-Union
Rifner, E. S.	Van Buren	Grant	Ross, James S.	Richmond	Wayne-Union
Rigg, J. F.	Indianapolis	Marion	Ross, W. W.	La Porte	La Porte
Riggs, Floyd	Terre Haute	Vigo	Rossiter, D. L.	Ft. Wayne	Allen
Rigley, E. L.	South Bend	St. Joseph	Rossow, Russell J.	Evansville	Vanderburgh
Riley, Frank (S)	Jamestown	Boone	Roth, Bertram	Indianapolis	Marion
Ringham, Jarrett	Evansville	Vanderburgh	Roth, James	Wolf Lake	Noble
Rininger, Harold C.	Evansville	Vanderburgh	Roth, Leo	Gary	Lake
Rinker, Earl B.	Indianapolis	Marion	Rothberg, Maurice J.	Ft. Wayne	Allen
Rinne, John I.	Lapel	Madison	Rothring, Howard E.	Columbus	Bartholomew- Brown
Riordan, John F.	Hammond	Lake	Rothrock, Philip W.	Lafayette	Tippecanoe
Ripley, John W.	Seymour	Jackson	Rothschild, C. J.	Ft. Wayne	Allen
Rissing, Walter J.	Ft. Wayne	Allen	Rotman, Harry G.	Jasonville	Greene
Ritchey, J. O.	Indianapolis	Marion	Rotman, Sam I.	Jasonville	Greene
Ritchie, William D.	Schertz, Tex.	Vanderburgh	Row, D. Hamilton	Indianapolis	Marion
Ritterman, George W.	Columbus	Bartholomew- Brown	Row, George S.	Osgood	Ripley
Ritter, Wayne L.	Indianapolis	Marion	Row, Perrie Q.	Hammond	Lake
Ritz, Albert S.	Evansville	Vanderburgh	Rowe, Howard H.	Rochester	Fulton
Rivers, Glynn A.	Muncie	Delaware- Blackford	Royster, Robert A.	Evansville	Vanderburgh
Robb, John A.	Indianapolis	Marion	Rozelle, Clarence V.	Anderson	Madison
Robertson, A. N.	New Albany	Floyd	Rubens, Eli	South Bend	St. Joseph
Robertson, D. W. (S)	Deputy	Jefferson- Switzerland	Rubin, Gerald S.	Indianapolis	Marion
Robertson, James S.	Plymouth	Marshall	Rubin, Milton M.	Terre Haute	Vigo
Robertson, M. O.	Bedford	Lawrence	Rubin, Simon S.	Gary	Lake
Robertson, Ray	Indianapolis	Marion	Ruddell, Karl R.	Indianapolis	Marion
Robertson, W. C.	Chesterton	Porter	Ruddell, Keith R.	Indianapolis	Marion
Robertson, William S.	Spiceland	Henry	Ruddick, H. C.	Evansville	Vanderburgh
Robinson, Earl U.	Evansville	Vanderburgh	Rudesill, C. L.	Indianapolis	Marion
Robinson, Frank C.	St. Peters- burg, Fla.	Marion	Rudesill, Robert	Indianapolis	Marion
Robinson, Walter K.	Gary	Lake	Rudicel, Max	Kokomo	Howard
			Rudolph, Carl J.	South Bend	St. Joseph
			Rudolph, F. G.	Hammond	Lake
			Rudolph, Stephen, Jr.	Scott, A.F.B., Ill.	Marion

Name	City	County	Name	City	County
Rudser, D. H.	Whiting	Lake	Schlademan, Karl R.	Ft. Wayne	Allen
Runge, Paul W.	Richmond	Wayne-Union	Schlagel, T. F., Jr.	Indianapolis	Marion
Rupe, Lloyd O.	Elkhart	Elkhart	Schlegel, Donald M.	Indianapolis	Marion
Rupel, Ernest	Indianapolis	Marion	Schlegel, Edward H.	Ft. Wayne	Allen
Rusche, Henry J.	Evansville	Vanderburgh	Schlemmer, George H.	Warsaw	Kosciusko
Ruschli, E. B.	Lafayette	Tippecanoe	Schlesinger, Daniel	Pittsburgh, Pa.	Lake
Rusk, Hubert M.	Wallace	Fountain-	Schlesinger, Jacob	Hammond	Lake
		Warren	Schlosser, H. C.	Elkhart	Elkhart
Russell, Richard H.	Evansville	Vanderburgh	Schmidt, Eugene F.	Ft. Wayne	Allen
Rust, Byron K.	Indianapolis	Marion	Schmidt, Loren F.	Indianapolis	Marion
Ruth, Martin L.	Indianapolis	Marion	Schmidt, Richard H.	Indianapolis	Marion
Rutherford, C. W. (S)	Indianapolis	Marion	Schmiedicke, P. H.	Lafayette	Tippecanoe
Rutherford, Charles E.	Indianapolis	Marion	Schmitt, Richard K.	Columbus	Bartholomew-
Ryan, Glen V.	Indianapolis	Marion			Brown
Ryan, H. J.	Gary	Lake	Schmoll, Robert J.	Ft. Wayne	Allen
Ryan, William J.	Columbus	Bartholomew-	Schneider, Carl J.	Indianapolis	Marion
		Brown	Schneider, C. P.	Evansville	Vanderburgh
			Schneider, Kenneth	Nashville	Bartholomew-
					Brown
S			Schneider, Louis A.	Ft. Wayne	Allen
Sacks, Harry J.	Indianapolis	Marion	Schoen, Frederic L.	Ft. Wayne	Allen
Sage, Charles V., Jr.	Richmond	Wayne-Union	Schoolfield, Wm. E.	Orleans	Orange
Sage, Russell	Indianapolis	Marion	Schott, Edward J. (S)	Terre Haute	Vigo
Sagel, Jacob	Gary	Lake	Schreiner, John E.	Bremen	Marshall
Sahlman, Hans	Ft. Wayne	Allen	Schriefer, Victor V.	Evansville	Vanderburgh
Saint, William	New Castle	Henry	Schroeder, Henry	Washington	Daviess-
Sala, J. J.	Gary	Lake			Martin
Sala, Walter R.	Gary	Lake	Schuchman, Abe	Indianapolis	Marion
Salb, Leo A.	Jasper	Dubois	Schuchman, Gabriel	Indianapolis	Marion
Salb, Max C.	Indianapolis	Marion	Schuldt, T. S.	Pierceton	Kosciusko
Sallee, William T.	Greensburg	Decatur	Schulfer, Richard J.	Hammond	Lake
Salon, Harry W.	Ft. Wayne	Allen	Schulhof, M. G.	Muncie	Delaware-
Salon, N. L.	Ft. Wayne	Allen			Blackford
Salzman, Morris	Indianapolis	Marion	Schulze, Wm.	Vincennes	Knox
Samples, J. T. (S)	Boonville	Warrick	Schumaker, Robert A.	Terre Haute	Vigo
Sanders, Harry M.	Indianapolis	Marion	Schuman, Edith B.	Bloomington	Owen-Monroe
Sanders, J. A.	Auburn	De Kalb	Schuster, Dwight W.	Indianapolis	Marion
Sanderson, R. B.	South Bend	St. Joseph	Schutt, J. B.	Ligonier	Noble
Sandock, Isadore	South Bend	St. Joseph	Schwartz, Fred C.	Kokomo	Howard
Sandock, Louis F.	South Bend	St. Joseph	Scoins, W. H.	Ft. Wayne	Allen
Sandorf, M. H.	Indianapolis	Marion	Scott, Frank M.	South Bend	St. Joseph
Sandoz, Harry	South Bend	St. Joseph	Scott, G. D.	Sullivan	Sullivan
Saperstein, Morris	Muncie	Delaware-	Scott, George E.	Indianapolis	Marion
		Blackford	Scott, H. V.	Ft. Wayne	Allen
Sarver, Francis E.	Fort Wayne	Allen	Scott, Irvin H.	Sullivan	Sullivan
Saunders, J. L.	Newport	Parke-	Scott, I. W.	Indianapolis	Marion
		Vermillion	Scott, John S.	LaPorte	LaPorte
Savage, A. R.	Ft. Wayne	Allen	Scott, John R.	Indianapolis	Marion
Savery, C. E.	South Bend	St. Joseph	Scott, Robert P.	Indianapolis	Marion
Sayers, F. E.	Terre Haute	Vigo	Scott, Robert S.	Charlottesville	Hancock
Scamahorn, Malcolm O.	Pittsboro	Hendricks	Scott, S. L.	Indianapolis	Marion
Scamahorn, O. T.	Pittsboro	Hendricks	Scott, V. Brown	Shelbyville	Shelby
Scea, Wallace	Elwood	Madison	Scudder, A. N.	Brownsburg	Hendricks
Schaaf, Alvin	Jamestown	Boone	Scudder, J. A.	Edwardsport	Knox
Schaefer, C. R. (S)	Indianapolis	Marion	Seagle, William C.	Indianapolis	Marion
Schaefer, William C.	Evansville	Vanderburgh	Seal, Perry F.	Brookville	Fayette-
Schafer, William C.	Washington	Daviess-			Franklin
		Martin	Seaman, C. F.	Indianapolis	Marion
Schaible, E. L.	Gary	Lake	Sears, Don	Odon	Daviess-
Schantz, Richard	Remington	Jasper-			Martin
		Newton	Sears, M. Maywood (S)	Elkhart	Elkhart
Scharbrough, William	Medora	Jackson	Seat, Marshall H.	Washington	Daviess-
Schauwecker, Cleon M.	Greencastle	Putnam			Martin
Schechter, John S.	Indianapolis	Marion	Sedam, Herbert L.	Indianapolis	Marion
Scheetz, Marion R.	Lewisville	Henry	Segar, Louis H.	Indianapolis	Marion
Scheier, E. W.	Indianapolis	Marion	Seglin, Robbert	Hammond	Lake
Schell, Harry D.	Bloomington	Owen-Monroe	Seibel, Robert	Morgantown	Morgan
Schellhouse, Earl	Fort Wayne	Allen	Seidell, Martin A.	Rochester,	Marion
Schenck, Foss	Logansport	Cass		Minn.	
Scherb, Burton E.	Terre Haute	Vigo	Seitz, P. F. D.	Indianapolis	Marion
Scherschel, John P.	Bedford	Lawrence	Selby, K. E.	South Bend	St. Joseph
Schetgen, Joseph V.	Geneva	Adams	Sellers, Francis M.	South Bend	St. Joseph
Scheurich, Virgil	Oxford	Benton	Selsam, Etta B.	Terre Haute	Vigo
Schiller, Herbert A.	South Bend	St. Joseph	Senese, T. J.	Gary	Lake
Schimmelpfennig,	Marion	Grant	Sennett, C. M.	South Bend	St. Joseph
Robert W.			Sennett, Wm. K.	Macy	Miami
Schirmer, Robert H.	Evansville	Vanderburgh	Sensenich, R. L.	South Bend	St. Joseph

Name	City	County	Name	City	County
Senseny, Eugene F.	Fort Wayne	Allen	Silbert, David	Shelbyville	Shelby
Senseny, Herbert	Ft. Wayne	Allen	Silverman, Norman M.	Terre Haute	Vigo
Seward, G. W.	N. Manchester	Wabash	Silver, Richard A.	Muncie	Delaware- Blackford
Sexson, Hiram	Indianapolis	Marion	Silvian, Harry	Whiting	Lake
Seybert, J. D.	Kendallville	Noble	Simmons, Frederick H.	Marion	Grant
Seyler, Anna G.	Crown Point	Lake	Simmons, L. H.	Goshen	Elkhart
Shacklett, Henry B. (S)	New Albany	Floyd	Simms, J. Leon	Indianapolis	Marion
Shafer, J. W. (S)	Lafayette	Tippecanoe	Simon, A. R.	La Porte	La Porte
Shafer, Marion R.	Indianapolis	Marion	Simpson, Wm. D.	Indianapolis	Marion
Shafer, Richard H.	Alexandria	Madison	Sims, J. Lawrence	Indianapolis	Marion
Shafer, Sid J.	Chicago, Ill.	Lake	Singer, E. C.	Ft. Wayne	Allen
Shaffer, K. L.	Vincennes	Knox	Sirlin, E. M.	Mishawaka	St. Joseph
Shallenberger, H. R.	Modoc	Randolph	Sisson, Helen M.	Westville	LaPorte
Shanklin, E. M. (S)	Hammond	Lake	Skeen, E. D.	Gary	Lake
Shanklin, V. A.	Terre Haute	Vigo	Skillern, P. G.	South Bend	St. Joseph
Shanks, Ray W.	Noblesville	Hamilton	Skomp, Claud E.	Marion	Grant
Shapiro, Burton J.	Terre Haute	Vigo	Skrentny, Stanley	Hammond	Lake
Shapiro, Joseph	East Chicago	Lake	Slabaugh, J. S. (S)	Nappanee	Elkhart
Sharman, Edward J.	Marion, Ill.	Jefferson- Switzerland	Slama, George	Gary	Lake
Sharp, John L.	Crawfordsville	Montgomery	Slama, John T.	Gary	Lake
Sharp, Merle C.	South Bend	St. Joseph	Slaughter, Howard C.	Evansville	Vanderburgh
Sharp, W. L.	Anderson	Madison	Slaughter, John	Evansville	Vanderburgh
Shattuck, John C.	Brazil	Clay	Slaughter, Owen L.	Evansville	Vanderburgh
Sheehan, Francis G.	Indianapolis	Marion	Slick, C. R.	Lynn	Randolph
Sheek, Kenneth I.	Greenwood	Johnson	Slimp, Thomas E.	Logansport	Cass
Sheets, Charles E.	Manilla	Rush	Sloan, H. P.	New Albany	Floyd
Sheller, Thomas G.	Argos	Marshall	Slominski, H. H.	South Bend	St. Joseph
Shelley, Edward	South Bend	St. Joseph	Sloss, I. H.	Terre Haute	Vigo
Shellhouse, Michael	Gary	Lake	Sluss, David H.	Indianapolis	Marion
Shenk, E. M.	Kokomo	Howard	Sluss, John W. (S)	Indianapolis	Marion
Shepard, Fred F.	College Cor- ner, Ohio	Wayne-Union	Smallwood, R. B.	Bedford	Lawrence
Sherman, Robert M.	Bluffton	Wells	Smelser, H. W.	Connersville	Fayette- Franklin
Sherster, Harry	Indianapolis	Marion	Smith, B. J.	Kingman	Fountain- Warren
Sherwood, Clarence	Fort Wayne	Allen	Smith, Charles G.	Otterbein	Benton
Sherwood, J. V.	Ft. Wayne	Allen	Smith, David J.	Indianapolis	Marion
Shevick, Alexander	Gary	Lake	Smith, D. L.	Indianapolis	Marion
Shields, Harry A.	Washington	Daviess- Martin	Smith, Don C.	Hope	Bartholomew- Brown
Shields, Jack E.	Brownstown	Jackson	Smith, E. Rogers	Indianapolis	Marion
Shields, Tom S.	Richmond	Wayne-Union	Smith, Francis C.	Indianapolis	Marion
Shinabery, Lawrence	Ft. Wayne	Allen	Smith, Frederick R.	Spencer	Owen-Monroe
Shively, John A.	Bluffton	Wells	Smith, G. A.	New Haven	Allen
Sholty, W. M.	Lafayette	Tippecanoe	Smith, Gloster J.	Kokomo	Howard
Shonk, Harold W.	Noblesville	Hamilton	Smith, H. N.	Brookville	Fayette- Franklin
Short, John	Ft. Wayne	Allen	Smith, H. S.	Bloomington	Owen-Monroe
Shortall, James P.	Michigan City	LaPorte	Smith, James M.	Indianapolis	Marion
Shortridge, W. H.	Seymour	Jackson	Smith, James S.	Muncie	Delaware- Blackford
Shoup, H. B.	Greentown	Howard	Smith, Jay W.	Indianapolis	Marion
Showalter, John P.	Waterloo	De Kalb	Smith, L. C.	Lafayette	Tippecanoe
Showalter, John R.	Terre Haute	Vigo	Smith, L. W.	Warren	Huntington
Shrigley, Edw. W.	Indianapolis	Marion	Smith, Lee	Lakeville	St. Joseph
Shrock, E. E.	Amboy	Miami	Smith, Lester A.	Indianapolis	Marion
Shroyer, Herbert	Dunkirk	Jay	Smith, Marsh H.	Goodland	Jasper- Newton
Shuck, Wm. A.	Madison	Jefferson- Switzerland	Smith, Paul E.	Bloomington	Owen-Monroe
Shugart, Joseph D.	Indianapolis	Marion	Smith, Philip L.	Ft. Wayne	Allen
Shullenberger, W. A.	Indianapolis	Marion	Smith, Ralph O.	Vincennes	Knox
Shulruff, H. I.	East Chicago	Lake	Smith, Robert A.	New Castle	Henry
Shultz, H. M. (S)	Logansport	Cass	Smith, R. D. (S)	Bloomington	Owen-Monroe
Shumacker, H. B., Jr.	Indianapolis	Marion	Smith, R. Lee	Osgood	Ripley
Sibbitt, Joseph W.	Bloomington	Owen-Monroe	Smith, Richard B.	New Haven	Allen
Sicks, O. W.	Indianapolis	Marion	Smith, Roy L.	Indianapolis	Marion
Sidebottom, Earl	Indianapolis	Marion	Smith, S. Joseph	Vincennes	Knox
Siebenmorgen, Louis	Terre Haute	Vigo	Smith, T. J.	Whiting	Lake
Siebenmorgen, Paul	Terre Haute	Vigo	Smith, Wilbur F.	Indianapolis	Marion
Siegman, Edw. L.	Terre Haute	Vigo	Smith, William B.	Indianapolis	Marion
Siekerman, C. W.	Indianapolis	Marion	Smoot, Emory B.	Washington	Daviess- Martin
Siekierski, J. M.	Griffith	Lake	Smoots, S. A.	Terre Haute	Vigo
Siersdorfer, T. N.	Indianapolis	Marion	Sneary, K. D.	Avilla	Noble
Sigmond, Harvey W.	Indianapolis	Marion	Sneed, William	Rockford, Ill.	Delaware- Blackford
Sigmund, Wm. B.	Columbus	Bartholomew- Brown			
Silberman, Jack	East Chicago	Lake			

Name	City	County	Name	City	County
Snider, Byron	Indianapolis	Marion	Stayton, Chester A., Jr.	Indianapolis	Marion
Snively, W. D., Jr.	Evansville	Vanderburgh	Steckler, Robert J.	Evansville	Vanderburgh
Snyder, E. R.	Troy	Perry	Stecy, Peter	Whiting	Lake
Snyder, Morris C.	Richmond	Wayne-Union	Steele, Dick J.	Greencastle	Putnam
Snyderman, Sanford C.	Fort Wayne	Allen	Steele, E. B.	Crown Point	Lake
Solomon, R. A.	Indianapolis	Marion	Steele, Paul W.	Evansville	Vanderburgh
Solomon, Robert D.	Terre Haute	Vigo	Steen, Lowell H.	Whiting	Lake
Somers, G. H.	Ft. Wayne	Allen	Steffen, A. J.	Wabash	Wabash
Soper, Hunter A.	Emmettsburg,	Marion	Steffen, J. T.	Wabash	Wabash
	Iowa		Steffy, Ralph M.	Portland	Jay
Sorenson, Raymond	Kokomo	Howard	Steinkamp, Emil F.	Huntingburg	Dubois
Souder, Bonnell M.	Auburn	De Kalb	Steinman, H. E.	Monroeville	Allen
Souter, Martha C.	Indianapolis	Marion	Stellner, Howard A.	Ft. Wayne	Allen
Southard, C. B.	Noblesville	Hamilton	Stemm, W. H. (S)	North Vernon	Jennings
Sovine, Joe W.	Indianapolis	Marion	Stephens, Donald E.	Indianapolis	Marion
Spahr, D. E.	Portland	Jay	Stephens, K. H.	Indianapolis	Marion
Spahr, John F.	Indianapolis	Marion	Stephens, Lowell R.	Covington	Fountain-
Spalding, J. J.	Indianapolis	Marion			Warren
Spalding, W. L.	Mishawaka	St. Joseph	Stepleton, John D.	Richmond	Wayne-Union
Spangler, Jesse S.	Kokomo	Howard	Stern, Nathan	Indianapolis	Marion
Sparks, A. Jerome	Ft. Wayne	Allen	Stern, S. L.	Hammond	Lake
Sparks, Alan L.	Indianapolis	Marion	Sterne, John H.	Evansville	Vanderburgh
Sparks, Paul W.	Winchester	Randolph	Stevens, Edwin W.	Calumet City,	Lake
Spears, John K.	Paoli	Orange		Ill.	
Spears, John M.	Hobart	Lake	Stevens, S. L.	Indianapolis	Marion
Speas, Robert C.	Terre Haute	Vigo	Stewart, Milton B. (S)	Logansport	Cass
Spellman, Frank A.	Gary	Lake	Stewart, O. H.	Aurora	Dearborn-
Spencer, Beaufort A.	Bloomington	Owen-Monroe			Ohio
Spencer, Frederic	Vincennes	Knox	Stewart, W. E.	Terre Haute	Vigo
Spencer, Hugh B.	Tulsa, Okla.	Marion	Sthair, Phillip L.	Indianapolis	Marion
Spenner, R. W.	South Bend	St. Joseph	Stier, Paul L.	Ft. Wayne	Allen
Spieth, Wm. H.	Lebanon	Boone	Stillwell, William R.	Richmond	Wayne-Union
Spigler, James	Terre Haute	Vigo	Stimson, H. R.	Gary	Lake
Spindler, Robert D.	Shelbyville	Shelby	Stine, Marshall E.	Bremen	Marshall
Spinning, Alva (S)	Michigan City	LaPorte	Stinson, A. E.	Rochester	Fulton
Spivack, Mary	Gary	Lake	Stinson, Dean K.	Rochester	Fulton
Spivey, R. J.	Indianapolis	Marion	Stiver, Daniel	South Bend	St. Joseph
Spolyar, L. W.	Indianapolis	Marion	Stocking, B. W.	Muncie	Delaware-
Sponder, Joseph	Gary	Lake			Blackford
Spray, Page E.	Elkhart	Elkhart	Stoelting, J. Lewis	Terre Haute	Vigo
Springstun, C. L.	Chrisney	Spencer	Stoelting, V. K.	Indianapolis	Marion
Springstun, George	Oaktown	Knox	Stogdill, William J.	South Bend	St. Joseph
Springstun, W. R.	Evansville	Vanderburgh	Stoler, A. E.	Ft. Wayne	Allen
Spurgeon, O. E. (S)	Muncie	Delaware-	Stone, A. T.	Indianapolis	Marion
		Blackford	Stone, David F.	Indianapolis	Marion
Spurlock, Fae	W. Lafayette	Tippecanoe	Stoops, Jean T.	Wabash	Wabash
Sputh, Carl B., Sr.	Indianapolis	Marion	Storer, Wm. R.	Hobart	Lake
Sputh, Carl B., Jr.	Indianapolis	Marion	Storey, D. E.	Indianapolis	Marion
Sroka, Alexander G.	Hammond	Lake	Storey, Joseph L.	Indianapolis	Marion
Sroka, Stanley J.	Highland	Lake	Stork, Harvey K.	Huntingburg	Dubois
	(Hammond)		Stork, Urban	Evansville	Vanderburgh
Stadler, Harold E.	Indianapolis	Marion	Storms, Roy B.	Indianapolis	Marion
Staff, Robert A.	Rockville	Parke-	Stouder, Albert E.	Kempton	Tipton
		Vermillion	Stouder, Charles E.	Gosport	Owen-Monroe
Stafford, J. C.	Plainfield	Hendricks	Stout, Francis E.	Muncie	Delaware-
Stafford, W. C.	Plainfield	Hendricks			Blackford
Stahl, Edward	Lafayette	Tippecanoe	Stout, Harry T.	Frankfort	Clinton
Stallman, Carl F.	Kendallville	Noble	Stout, R. B.	Elkhart	Elkhart
Stalter, Gaylord W.	N. Webster	Kosciusko	Stout, Walter M.	New Castle	Henry
Stamper, J. H.	Anderson	Madison	Stover, Wendell C.	Boonville	Warrick
Stamper, L. Allen	Richmond	Wayne-Union	Stoycoff, C. M.	Gary	Lake
Stangle, W. J.	Bloomington	Owen-Monroe	Strange, Dempsey C.	Indianapolis	Marion
Stanley, John R.	Muncie	Delaware-	Stratigos, Jos. S.	South Bend	St. Joseph
		Blackford	Strayer, J. W.	Lafayette	Tippecanoe
Stanley, J. S.	Indianapolis	Marion	Streck, F. A.	Lawrenceburg	Dearborn-
Stanton, J. J.	Logansport	Cass			Ohio
Starks, William O.	Muncie	Delaware-	Strecker, Wm. L.	Terre Haute	Vigo
		Blackford	Streepey, J. I.	New Albany	Floyd
Stasick, Murray	Hammond	Lake	Strickland, Karl S.	Owensville	Gibson
Staten, Jesse C.	Indianapolis	Marion	Strickland, Martha B.	Lafayette	Tippecanoe
Stauffer, George E.	Mooreland	Henry	Strong, Daniel S. (S)	Terre Haute	Vigo
Stauffer, Richard C.	Ft. Wayne	Allen	Stroup, Tyler J.	Indianapolis	Marion
Stauffer, Walter A. (S)	Elkhart	Elkhart	Strueh, Paul E.	Evansville	Vanderburgh
Staunton, Henry A.	South Bend	St. Joseph	Stubbins, William M.	Elkhart	Elkhart
Stayton, C. A.	Indianapolis	Marion	Stuckman, E. D. (S)	New Paris	Elkhart
			Stucky, Ellsworth	Indianapolis	Marion

Name	City	County	Name	City	County
Studebaker, Lloyd R.	LaGrange	LaGrange	Thom, Julia S.	Indianapolis	Marion
Stultz, Q. F.	Ligonier	Noble	Thomas, C. E. (S)	Leesburg	Kosciusko
Stumer, Myer	Michigan City	LaPorte	Thomas, Daniel D.	Gary	Lake
Stump, Thomas A.	Indianapolis	Marion	Thomas, Edward P.	Indianapolis	Marion
Stumpf, Edwin E.	New Haven	Clark	Thomas, Everett W.	Warsaw	Kosciusko
Sturgis, Donald G.	Sellersburg	Clark	Thomas, Fred A.	Indianapolis	Marion
Stygall, James H.	Indianapolis	Marion	Thomas, G. A.	Lafayette	Tippecanoe
Sudranski, Herbert F.	Indianapolis	Marion	Thomas, Gerald J.	Gary	Lake
Sugarman, Benj. E.	French Lick	Orange	Thomas, Lowell I.	Indianapolis	Marion
Sullenger, A. A.	Vincennes	Knox	Thomas, Morris E.	Indianapolis	Marion
Sullivan, John M.	Terre Haute	Vigo	Thomas, Ralph G.	Ft. Custer, Mich.	Marion
Sutter, Charles C.	Evansville	Vanderburgh	Thompson, A. A.	Tyner	Marshall
Sutton, Wm. E.	Indianapolis	Marion	Thompson, Chas. F.	Indianapolis	Marion
Suzuki, Tsutomu T.	Covington	Fountain- Warren	Thompson, Frank	Columbia City	Whitley
			Thompson, Holland	Ft. Wayne	Allen
Swan, John R.	Indianapolis	Marion	Thompson, John M.	South Bend	St. Joseph
Swan, Richard Carl	Anderson	Madison	Thompson, J. V.	Indianapolis	Marion
Swank, L. Forrest	Elkhart	Elkhart	Thompson, Lewis	New Harmony	Posey
Swayne, J. F.	Indianapolis	Marion	Thompson, Noah (S)	Bedford, Va.	Wabash
Sweet, Edward M. (S)	Martinsville	Morgan	Thompson, Paul D.	Indianapolis	Marion
Sweet, Howard E.	Richmond	Wayne-Union	Thompson, Robert A.	South Bend	St. Joseph
Swihart, Homer R.	Elkhart	Elkhart	Thompson, W. A. (S)	Liberty	Wayne- Union
Swihart, L. F.	Elkhart	Elkhart			
Switzer, Robert E.	Bethesda, Md.	Noble	Thompson, Wm. R.	Winamac	Pulaski
Symmes, Alfred T.	Indianapolis	Marion	Thornburg, Kenneth	Indianapolis	Marion
Szynal, John S.	Indianapolis	Marion	Thorne, C. E.	New Castle	Henry
			Thornton, Harold C.	Indianapolis	Marion
Tager, Stephen	Evansville	Vanderburgh	Thornton, Maurice J.	South Bend	St. Joseph
Take, J. F. (S)	French Lick	Orange	Thornton, Walter E.	Ft. Wayne	Allen
Talbert, Pierre C.	Bluffton	Wells	Thrasher, John R.	Indianapolis	Marion
Talbott, Dan E.	Indianapolis	Marion	Thurston, H. S. (S)	Indianapolis	Marion
Tanner, Henry S.	Indianapolis	Marion	Tilden, Margaret	Evansville	Vanderburgh
Taube, Jack I.	Indianapolis	Marion	Tiley, George	Greenwood	Johnson
Taylor, C. C.	Indianapolis	Marion	Tilka, Edward	Hammond	Lake
Taylor, E. C.	Upland	Grant	Tindal, E. F. (S)	Muncie	Delaware- Blackford
Taylor, Eugene E.	Bloomington	Owen- Monroe			
			Tindall, George T.	Indianapolis	Marion
Taylor, F. W.	Indianapolis	Marion	Tindall, Paul R.	Shelbyville	Shelby
Taylor, James A. (S)	Montpelier	Delaware- Blackford	Tindall, Wm. R.	Shelbyville	Shelby
			Tinney, W. E.	Indianapolis	Marion
Taylor, Lon S.	Elberfeld	Warrick	Tinsley, Frank W.	Indianapolis	Marion
Taylor, W. H.	Ambia	Benton	Tinsley, W. B.	Indianapolis	Marion
Taylor, W. R.	Richmond	Wayne-Union	Tinsley, Walter B., Jr.	Indianapolis	Marion
Teaford, S. F. (S)	Paoli	Orange	Tipton, Wm. R.	Greencastle	Putnam
Teague, Frank	Indianapolis	Marion	Tirman, Wallace S.	Bluffton	Wells
Teal, Dorothy D.	Columbus	Bartholomew- Brown	Tischer, E. Paul	Indianapolis	Marion
			Titus, Charles (S)	Wilkinson	Hancock
Teegarden, J. A., Jr.	East Chicago	Lake	Todd, David D.	Elkhart	Elkhart
Teegarden, J. A., Sr.	East Chicago	Lake	Tomak, Milton E.	Linton	Greene
Teixler, V. A.	Indianapolis	Marion	Tomlin, Hugh M.	Muncie	Delaware- Blackford
Templeton, Ames R.	Mishawaka	St. Joseph			
Templin, D. B.	Lowell	Lake	Tomlinson, C. H. (S)	Cicero	Hamilton
Tennant, David L.	Alexandria, La.	Allen	Topek, Nathan H.	Offutt, A.F.B., Neb.	Marion
Tennis, George	Greencastle	Putnam	Topoligus, James N.	Bloomington	Owen-Monroe
Teplinsky, L. Louis	Munster	Lake	Topping, M. C.	Terre Haute	Vigo
Terflinger, F. W. (S)	Logansport	Cass	Torella, J. A.	Indianapolis	Marion
Terrill, R. W.	Ft. Wayne	Allen	Tosick, William A.	Indianapolis	Marion
Terry, Lloyd	Danville	Hendricks	Toumey, Fred L.	Indianapolis	Marion
Terveer, John B.	Decatur	Adams	Tower, Thomas K.	Campbellsburg	Washington
Test, Charles E.	Indianapolis	Marion	Townsend, Ralph	Westville	LaPorte
Teter, Geo. V., Jr.	Indianapolis	Marion	Tracy, Julius R.	Anderson	Madison
Teters, Melvin S.	Middlebury	Elkhart	Tranter, W. F.	Sharpsville	Tipton
Tether, Joseph E., Jr.	Indianapolis	Marion	Traver, P. C.	South Bend	St. Joseph
Tetrick, Elbert L.	Evanston, Ill.	Marion	Travis, J. C., Jr.	Logansport	Cass
			Tremain, M. A. (S)	Adams	Decatur
Tharp, Harold R.	Xenia, Ohio	Marion	Treon, James F.	Aurora	Dearborn- Ohio
Tharpe, Ray	Indianapolis	Marion			
Thatcher, H. K., Jr.	Indianapolis	Marion	Trepagnier, Francis B.	East Chicago	Lake
Thayer, B. W.	North Vernon	Jennings	Trinosky, Donald L.	Gary	Lake
Thayer, J. O.	Noblesville	Hamilton	Tripp, H. D.	Bloomington	Owen-Monroe
Thegze, George	Whiting	Lake	Trout, C. J.	Lafayette	Tippecanoe
Theye, Richard A.	Fort Wayne	Allen	Troutwine, William	Crown Point	Lake
Thill, Leonard J.	Auburn	De Kalb	Troy, Jack M.	Whiting	Lake
Thimlar, J. W.	Ft. Wayne	Allen			
Thom, Jay W.	Indianapolis	Marion			

Name	City	County	Name	City	County
Truman, Elmer M., Jr.	Columbus, O.	Rush	Viehe, Robert W.	Evansville	Vanderburgh
Trusler, H. M.	Indianapolis	Marion	Vietzke, P. C. F.	Valparaiso	Porter
Tubbs, George R. (S)	Lafayette	Tippecanoe	Vingus, Bronie	Greenfield	Hancock
Tuchman, Joseph H.	Indianapolis	Marion	Viney, Charles L.	Logansport	Cass
Tucker, O. A.	Daleville	Delaware- Blackford	Visher, John W.	Evansville	Vanderburgh
Tucker, Robert L.	Indianapolis	Marion	Vivian, Donald E.	New Castle	Henry
Tucker, Warren S.	Indianapolis	Marion	Vlaskamp, Elaine	Muncie	Delaware- Blackford
Tully, J. A. (S)	New Castle	Henry	Vogel, L. John	Mt. Vernon	Posey
Turgi, Robert W.	Gary	Lake	Voges, Edward C.	Terre Haute	Vigo
Turley, Verne L.	Fowler	Benton	Voisinet, R. A.	Union City	Randolph
Turner, Anna Goss	Madison	Jefferson- Switzerland	Vollrath, Victor J.	Indianapolis	Marion
Turner, H. B.	Bloomfield	Greene	VonAsch, George	LaPorte	LaPorte
Turner, Jack J.	Bloomfield	Greene	Von Der Haar, Gerard	Indianapolis	Marion
Turner, John P.	Goshen	Elkhart	Vore, Hugh A.	Highland	Lake
Turner, Maurice A.	Oakland City	Gibson	Vore, L. W.	Plymouth	Marshall
Turner, Oscar A.	Madison	Jefferson- Switzerland	Voyles, C. F. (S)	Indianapolis	Marion
Turner, Robert	Muncie	Delaware- Blackford	Voyles, Harry	New Albany	Floyd
Turrell, Eugene S.	Denver, Colo.	Marion	Vurpillat, Francis J.	South Bend	St. Joseph
Tweedall, D. C.	Evansville	Vanderburgh	Vye, James P.	Gary	Lake
Tweedall, D. G.	Evansville	Vanderburgh		W	
Tyler, F. T.	New Albany	Floyd	Wade, A. A.	Howe	LaGrange
Tyler, Robert L.	Columbia City	Whitley	Wagner, Arthur L.	Jasper	Dubois
Tyner, Harlan H.	Indianapolis	Marion	Wagner, David G.	Goshen	Elkhart
Tyrrell, Thomas C.	Calumet City, Ill.	Lake	Wagoner, G. W.	Delphi	Carroll
	U		Wagoner, John R.	Delphi	Carroll
Uhrich, John H.	Monroeville	Allen	Waite, Earl L. (S)	Macy	Miami
Urschel, Dan L.	Mentone	Kosciusko	Waldo, J. Thayer	Indianapolis	Marion
Utterback, Arnold	Terre Haute	Vigo	Walerko, Frank	Mishawaka	St. Joseph
	V		Walker, Adolph B.	Hammond	Lake
Vagner, Bernard	South Bend	St. Joseph	Walker, F. C.	Indianapolis	Marion
Vail, George A.	Lawrenceburg	Dearborn- Ohio	Walker, Floyd B.	Fort Wayne	Allen
VanArsdall, C. R.	Terre Haute	Vigo	Walker, Jack M.	Plainfield	Hendricks
VanBokkelen, Robert	Mooreville	Morgan	Walker, J. L.	LaFontaine	Wabash
Van Buskirk, E. L.	Lafayette	Tippecanoe	Walker, Robert K.	Indianapolis	Marion
Vance, Wm. C.	Richmond	Wayne- Union	Wall, Joseph A.	Wabash	Wabash
Van Den Bosch, W. R.	Westville	LaPorte	Wallace, Hawthorne C.	Crawfordsville	Montgomery
Vandevent, Arthur	Sellersburg	Clark	Walters, Charles E.	Mishawaka	St. Joseph
Vandivier, R. M.	Indianapolis	Marion	Walters, Eleanore	Gary	Lake
VanDorn, Myron J.	Indianapolis	Marion	Walters, William	Michigan City	LaPorte
VanFleet, Josephine	Indianapolis	Marion	Walther, Joseph E.	Indianapolis	Marion
Van Kirk, George H.	Kentland	Jasper- Newton	Waltz, Frank C.	Punta Gorda, Fla.	Kosciusko
VanKirk, J. A.	Frankfort	Clinton	Wanninger, Horace	Richmond	Wayne- Union
VanKirk, John R.	Burlington	Carroll			
VanKirk, Paul P.	Frankfort	Clinton	Ward, H. H. (S)	Coalmont	Clay
VanMeter, C. Powell	Indianapolis	Marion	Ward, J. W.	Mishawaka	St. Joseph
VanNess, William C.	Summitville	Madison	Ward, Jos. H.	Indianapolis	Marion
VanNest, W. A.	New Smyrna Beach, Fla.	Dekalb	Ward, Wesley C.	Indianapolis	Marion
Van Nuys, John D.	Indianapolis	Marion	Ware, J. R.	Huntington	Huntington
VanNuys, W. C. (S)	Indianapolis	Marion	Warfel, F. C.	Indianapolis	Marion
VanOsdol, H. A.	Indianapolis	Marion	Warfield, Chester H.	Ft. Wayne	Allen
Van Rie, L. P.	Mishawaka	St. Joseph	Warman, A. P.	Indianapolis	Marion
Van Sandt, Frank A. (S)	Bloomfield	Greene	Warn, William J.	Milan	Ripley
VanTassel, Charles J.	Indianapolis	Marion	Warne, G. H.	Tipton	Tipton
VanVactor, Helen D.	Indianapolis	Marion	Warren, Frank R. (S)	Michigan City	LaPorte
Van Wiene, John	Martinsville	Morgan	Warren, Carroll B.	Marion	Grant
VanWinkle, Arthur J.	Valparaiso	Porter	Warrick, Francis B.	Richmond	Wayne- Union
Varble, William (S)	Jeffersonville	Clark			
Veach, Lester W.	Bainbridge	Putnam	Warrick, Homer L.	Osceola	St. Joseph
Veach, Richard L.	Bainbridge	Putnam	Warriner, James B.	Indianapolis	Marion
Veazey, Wm. (S)	Avilla	Noble	Warvel, J. H.	Indianapolis	Marion
Vellios, Frank	Indianapolis	Marion	Warvel, Joseph L. (S)	N. Manchester	Wabash
Venable, George L.	N. Manchester	Wabash	Washburn, W. W.	Lafayette	Tippecanoe
Venis, Kemper N.	Muncie	Delaware- Blackford	Washington, G. Kenneth	Gary	Lake
Vermilya, R. W.	Lafayette	Tippecanoe	Watson, James L.	Evansville	Vanderburgh
Verplank, G. L.	Gary	Lake	Watterson, Gerald T.	Connersville	Fayette- Franklin
			Waymire, E. S.	Indianapolis	Marion
			Weaver, T. M. (S)	Brazil	Clay
			Weaver, Wm. W.	New Albany	Floyd
			Webb, Harry D.	Anderson	Madison
			Weber, Edgar H.	Evansville	Vanderburgh
			Weber, John R.	Ft. Wayne	Allen
			Weber, Joseph G. S.	Terre Haute	Vigo
			Weber, Norbert	Fort Wayne	Allen

Name	City	County	Name	City	County
Webster, Paul L.	Ligonier	Noble	Wilhelm, Agatha M.	South Bend	St. Joseph
Webster, R. K.	Brazil	Clay	Wilhelmus, C. Kenneth	Evansville	Vanderburgh
Weddle, Chas. O.	Lebanon	Boone	Wilhelmus, Charles M.	Newburgh	Warrick
Weeks, P. H.	Michigan City	LaPorte	Wilhelmus, Gilbert	Evansville	Vanderburgh
Weems, M. P.	Jeffersonville	Clark	Wilhelmus, Wm. M.	Evansville	Vanderburgh
Wegner, William G. (S)	South Bend	St. Joseph	Wilkens, I. W.	Indianapolis	Marion
Wehrman, J. O. (S)	Indianapolis	Marion	Wilkerson, Edward L.	A.P.O. 42, New York	Vigo
Weigand, C. G.	Indianapolis	Marion	Wilkins, R. W.	Ft. Wayne	Allen
Weil, H. J.	Indianapolis	Marion	Wilkinson, Roger L.	Anderson	Madison
Weinberg, B. A.	Whiting	Lake	Willan, H. R.	Martinsville	Morgan
Weinberg, Samuel	Marion	Grant	Williams, A. H.	Ft. Wayne	Allen
Weinland, George C.	Indianapolis	Marion	Williams, Alexander S.	Gary	Lake
Weinstein, E. B.	Richmond	Wayne- Union	Williams, Berniece	Ft. Wayne	Allen
Weinstein, J. H. (S)	Terre Haute	Vigo	Williams, Charles D.	Indianapolis	Marion
Weinstock, Adolph	Rolling Prairie	LaPorte	Williams, Charles E.	Huntingburg	Dubois
Weir, Dale	LaGrange	LaGrange	Williams, C. L.	Indianapolis	Marion
Weirich, Charles I.	Butler	Dekalb	Williams, Everett W.	Columbus	Bartholomew- Brown
Weis, William D. (S)	Crown Point	Lake	Williams, F. M., Jr.	Anderson	Madison
Weiskopf, Henry S.	Gary	Lake	Williams, F. P.	Huntingburg	Dubois
Weiss, Eugene	South Bend	St. Joseph	Williams, Frederic N.	Mt. Vernon	Posey
Weiss, H. G. (S)	Evansville	Vanderburgh	Williams, H. J.	Morocco	Jasper- Newton
Weiss, Jason	Indianapolis	Marion	Williams, H. O.	Kendallville	Noble
Weitzel, Roland	Princeton	Gibson	Williams, H. S., Jr.	Indianapolis	Marion
Welborn, Mell B.	Evansville	Vanderburgh	Williams, Hugh L.	Indianapolis	Marion
Welch, Norbert M.	Vincennes	Knox	Williams, John H.	Muncie	Delaware- Blackford
Weldy, Bryce P.	Hartford City	Delaware- Blackford	Williams, John H.	Shipshewana	LaGrange
Weller, Charles A.	Indianapolis	Marion	Williams, Paul D.	Richmond	Wayne-Union
Wellpott, Jean F.	Bloomington	Owen-Monroe	Williams, Robert D.	Markleville	Madison
Welty, S. G.	Ft. Wayne	Allen	Williams, R. H.	Anderson	Madison
Werry, L. E.	Hartford City	Delaware- Blackford	Willis, Charles F.	Evansville	Vanderburgh
Wertenberger, Morris D.	Richmond	Wayne- Union	Willison, George	Evansville	Vanderburgh
West, Joseph L.	Indianapolis	Marion	Willner, Alan	Clarksville	Clark
Westfall, B. Kemper	Indianapolis	Marion	Wills, Benjamin F.	Union City	Randolph
Westfall, George S.	Goshen	Elkhart	Wills, Max	Auburn	DeKalb
Westfall, John B.	Indianapolis	Marion	Willson, C. L.	Anderson	Madison
Westhaysen, Peter	Gary	Lake	Wilmore, Ralph C.	Indianapolis	Marion
Weyerbacher, A. F.	Indianapolis	Marion	Wilson, Douglas E.	Battle Creek, Mich.	Marion
Whallon, Arthur J.	Richmond	Wayne- Union	Wilson, Fred	Terre Haute	Vigo
Wharton, R. O.	Gary	Lake	Wilson, Fred M.	Indianapolis	Marion
Whipps, Charles E.	Carlisle	Sullivan	Wilson, Guy	Bicknell	Knox
Whisler, F. M.	Wabash	Wabash	Wilson, James	South Bend	St. Joseph
Whitcomb, Roger F.	Shelbyville	Shelby	Wilson, John D.	Evansville	Vanderburgh
White, C. S.	Rosedale	Parke- Vermillion	Wilson, Leslie	Ft. Wayne	Allen
White, Donald J.	Indianapolis	Marion	Wilson, O. E.	Elkhart	Elkhart
White, Harvey E.	Farmland	Randolph	Wilson, Oliver R.	Indianapolis	Marion
White, I. D. (S)	Clinton	Parke- Vermillion	Wilson, Paul	Boonville	Warrick
White, James V.	Terre Haute	Vigo	Wilson, P. H.	Logansport	Cass
White, John B.	Indianapolis	Marion	Wilson, Ralph	Evansville	Vanderburgh
White, Philip T.	Rochester, Minn.	Marion	Wilson, Ralph (S)	Shirley	Henry
White, W. J. (S)	Gary	Lake	Wilson, Roland B.	Ft. Wayne	Allen
Whitehead, John M.	Indianapolis	Marion	Wilson, T. L.	Bloomington	Owen- Monroe
Whitlock, Francis C.	Mishawaka	St. Joseph	Wimmer, Robert N.	Gary	Lake
Whitlock, Merle E.	Mishawaka	St. Joseph	Winter, Donald K.	Logansport	Cass
Whitsitt, S. A. (S)	Madison	Jefferson- Switzerland	Winters, Matthew	Indianapolis	Marion
Wiatt, Leonard	Knightstown	Henry	Wise, Charles L.	Camden	Carroll
Wicker, Eugene H.	Marion	Grant	Wise, Wm.	Indianapolis	Marion
Wicks, O. C. (S)	Gary	Lake	Wise, William R.	Indianapolis	Marion
Wiedemann, F. E. (S)	Terre Haute	Vigo	Wiseheart, O. H. (S)	North Salem	Hendricks
Wierzalis, Edward F.	Hartford City	Delaware- Blackford	Wiseheart, Robert	Lebanon	Boone
Wiethoff, Clifford Allen	Seymour	Jackson	Wiseman, V. Earle	Greencastle	Putnam
Wiggins, D. S. (S)	New Castle	Henry	Wisener, G. H.	Richmond	Wayne- Union
Wilcox, R. F.	LaPorte	LaPorte	Wishard, Wm. N., Jr.	Indianapolis	Marion
Wilber, Harold R.	Jeffersonville	Clark	Wishart, S. W.	Evansville	Vanderburgh
Wilder, G. B.	Anderson	Madison	Wisniewski, Edward M.	Hammond	Lake
Wildman, R. E.	Peru	Miami	Wissman, William L.	Columbus	Bartholomew- Brown
			Witham, Robert L.	Culver	Marshall
			Witt, William R.	Jeffersonville	Clark
			Wixted, John F.	Mishawaka	St. Joseph

Name	City	County	Name	City	County
Wixted, Julia F.	Mishawaka	St. Joseph	Yeck, Charles W.	Evansville	Vanderburgh
Wohlfeld, Gerald	New Albany	Floyd	Yegerlehner, Roscoe	Kentland	Jasper-
Wohlfeld, J. B.	Bedford	Lawrence			Newton
Wolfe, William E.	LaPorte	LaPorte	Yencer, M. W. (S)	Richmond	Wayne-
Wolfe, Nelson	New Albany	Floyd			Union
Wolfram, Don J.	Indianapolis	Marion	Yochem, August S., Jr.	Indianapolis	Marion
Woner, John W.	Linton	Greene	Yocum, Paul S.	Gary	Lake
Wood, Amelia T.	Muncie	Delaware-	Yocum, William S.	Gary	Lake
		Blackford	Yoder, Albert C.	Goshen	Elkhart
Wood, Donald E.	Indianapolis	Marion	Yoder, D. D.	Columbus	Bartholomew-
Wood, Elmer U. (S)	Columbus	Bartholomew-			Brown
		Brown	Yoder, C. Richard	Columbus, O.	Elkhart
Wood, Frederick H.	Hammond	Lake	Yoder, Richard P.	Bluffton	Wells
Wood, Hobart	Camp	Bartholomew-	York, Arthur F.	St. Paul,	Madison
	Atterbury	Brown		Minn.	
Wood, Opal L.	Brazil	Clay	Young, C. Curtis	Evansville	Vanderburgh
Wood, R. W.	Oakland City	Gibson	Young, G. M.	Gary	Lake
Woodall, Earl C.	Indianapolis	Marion	Young, G. S.	Muncie	Delaware-
Woodard,	Indianapolis	Marion			Blackford
Abram S., Jr.			Young, James W.	Indianapolis	Marion
Woodbury, John W.	Marion	Grant	Young, John E.	Indianapolis	Marion
Woodcock, C. E.	Greenwood	Johnson	Young, John M.	Indianapolis	Marion
Woods, A. L.	Poseyville	Posey	Young, Ralph H.	Goshen	Elkhart
Woods, H. C.	Markle	Huntington	Young, Robert	Marion	Grant
Woods, James R.	Greenfield	Hancock	Young, Robert L.	Gary	Lake
Woods, Wm. P. (S)	Evansville	Vanderburgh	Young, S. J. (S)	Kendallville	Noble
Woolery, R. H.	Bedford	Lawrence	Young, W. C.	Indianapolis	Marion
Woolling, Kenneth R.	Indianapolis	Marion	Yunker, P. E.	Howe	LaGrange
Work, Bruce A.	Frankfort	Clinton			
Work, James A., Jr.	Elkhart	Elkhart		Z	
Worley, A. C.	Ft. Wayne	Allen	Zalac, Donald	Michigan City	LaPorte
Worley, J. P.	Indianapolis	Marion	Zallen, Stanley G.	East Chicago	Lake
Worley, Henry L.	New Albany	Floyd	Zaring, B. K.	Columbus	Bartholomew-
Worley, Richard H.	Indianapolis	Marion			Brown
Worth, C. W.	Milroy	Rush	Zehr, Noah	Ft. Wayne	Allen
Wright, Cecil S.	Anderson	Madison	Zeiger, Irvin	South Bend	St. Joseph
Wright, J. Wm., Jr.	Indianapolis	Marion	Zell, Evertson H.	Indianapolis	Marion
Wright, J. William	Indianapolis	Marion	Zeps, E. Frances	Evansville	Vanderburgh
Wright, W. C.	Ft. Wayne	Allen	Zerfas, Charles P. A.	Indianapolis	Marion
Wurster, H. C.	Mishawaka	St. Joseph	Zerfas, L. G.	Camby	Marion
Wyatt, Fred H.	Denver,	Vanderburgh	Zerfas, Phyllis	Indianapolis	Marion
	Colorado		Zierer, R. O.	Anderson	Madison
Wyatt, James L., II	Ft. Wayne	Allen	Zimmer, Henry J.	Mishawaka	St. Joseph
Wyatt, James L., III	Ft. Wayne	Allen	Zimmerman, Harold	Evansville	Vanderburgh
Wyeth, Charles (S)	Terre Haute	Vigo	Zimmerman, Wm. H.	Dublin	Wayne-Union
Wygant, M. D.	Mishawaka	St. Joseph	Zink, Robert O.	Madison	Jefferson-
Wyland, B. J.	Mishawaka	St. Joseph			Switzerland
Wynn, J. F.	Evansville	Vanderburgh	Ziperman, H. Haskell	A.P.O. San	Marion
Wynne, R. E.	Bedford	Lawrence		Francisco,	
Wytttenbach, Frederick	Indianapolis	Marion		Calif.	
Wytttenbach, John E.	Indianapolis	Marion	Zivich, John M.	East Chicago	Lake
			Zweig, E. S.	Ft. Wayne	Allen
Yale, Charles A.	Winamac	Pulaski	Zwerner, Paul F.	Terre Haute	Vigo
Yarling, J. E. (S)	Peru	Miami	Zwick, Harold F.	Decatur	Adams
Yarrington, C. W. (S)	Gary	Lake	Zwickel, R. E.	Evansville	Vanderburgh

ROSTER OF MEMBERS BY COUNTIES

Physicians are listed in the counties in which they reside.

(Paid up members of the Indiana State Medical Association as of June 1, 1953)

ADAMS COUNTY

Beaver, Norman Berne
 Lehman, Harold Berne
 Burk, James M. Decatur
 Carroll, John C. Decatur
 Girod, Arthur H. Decatur
 Kohne, Gerald J. Decatur
 Parrish, Richard K. Decatur
 Raymond, Louis F. Decatur
 Reppert, Roland L. Decatur
 Terveer, John B. Decatur
 Zwick, Harold F. Decatur
 Hinchman, Clarence P. Geneva
 Schetgen, Joseph V. Geneva
 Habbeger, Myron L.
 12 Magnolia St., Cocoa, Fla.

ALLEN COUNTY

Fort Wayne

A

Aiken, Arthur F. 1923 E. State
 Aiken, Nevin E. 1923 E. State St.
 Arata, Justin E.
 702 Med. Center Bldg. (2)

B

Bailey, Paul P.
 206 Medical Center Bldg. (2)
 Baltess, Jos. H. 821 Broadway (2)
 Bash, Wallace E. 111 Esmond
 Baumgartner, J. C.
 515 W. Wayne St. (2)
 Beams, Ralph
 517 Medical Center Bldg. (2)
 Beierlein, Karl M.
 334 Medical Center Bldg. (2)
 Benninghoff, D. R.
 208 Medical Center Bldg. (2)
 Bergendahl, Emil H.
 629 Medical Center Bldg. (2)
 Berghoff, R. J., 306 E. Jefferson (2)
 Bichacoff, Billie D.
 615 W. Wayne St. (2)
 Bickel, J. E. (S)
 2615 S. Lafayette (2)
 Blosser, H. V. (S) 309 W. Main (2)
 Bolman, Ralph M. 717 Broadway
 Bonner, Joseph N.
 2902 Fairfield Ave. (6)

Borders, Theodore R.
 1145 S. Lafayette (2)
 Bowers, G. T. 307 E. Jefferson (2)
 Bowers, J. W. 418 Gettle Bldg.
 Brosius, R. H. W. 1603 Wells (7)
 Brown, F. W.
 2301 Fairfield Ave. (6)
 Bruggeman, H. O.
 1202 Washington St. (2)
 Bryan, Franklin A.
 402 W. Washington Blvd.
 Buckner, Doster
 533 W. Washington St. (2)
 Buckner, George D.
 533 W. Washington St. (2)
 Bulson, Eugene L.
 229 W. Berry St. (2)

C

Calvin, J. C. (S) 312 W. Wayne (2)
 Cameron, Don F.
 102 Medical Center Bldg. (2)
 Carey, Willis W. (S)
 2525 S. Calhoun (5)
 Carlo, E. R. 2902 Fairfield (6)
 Cartwright, E. L.
 230 Medical Center Bldg. (2)
 Catlett, M. B. 232 W. Wayne (2)
 Chambers, A. R. 601 W. Wayne (2)
 Clark, W. R. 3622 S. Calhoun St.
 Cochran, Harry A., Jr.
 1301 S. Harrison
 Conley, J. E. 620 W. Berry (2)
 Cooney, C. J. 527 W. Berry (2)
 Cornell, B. S. 229 W. Berry St.
 Culp, J. E. 2902 Fairfield (6)

D

Dancer, C. R. (S)
 905 Columbia Ave.
 Datzman, Richard C.
 525 Medical Center Bldg. (2)
 Ditton, I. W. (S) 1214 E. Wayne (4)
 Duemling, A. H. 2902 Fairfield (6)
 Dunstone, H. C.
 502 Medical Center Bldg. (2)

E

Edlavitch, B. M. 716 Rockhill (2)
 Elston, Lynn W.
 622 Medical Center Bldg. (2)
 Elston, Ralph W.
 622 Medical Center Bldg. (2)
 Emenhiser, John L.
 R. 9, Maysville Rd.

F

Ferguson, Arthur N.
 2902 Fairfield Ave. (6)
 Fichman, A. M. 323 W. Berry (2)
 Foy, H. W. 1747 Wells St.

G

Garton, H. W. 1635 Broadway
 Gerding, W. J. 2638½ S. Calhoun
 Gladstone, N. H. 335 W. Berry (2)
 Glock, H. E. (S)
 324 Medical Center Bldg. (2)
 Glock, M. E. 312 W. Wayne (2)
 Glock, W. R. 2301 Fairfield Ave.
 Goebel, Carl W.
 213 W. Jefferson St.
 Gould, L. K. 3415 S. Fairfield (6)
 Graham, George M.
 Lincoln Nat. Life Ins. Co.
 Greist, Walter D.
 3024 Fairfield Ave. (6)

H

Haffner, H. G. 202 E. Jefferson (2)
 Haller, Robert L.
 604 W. Wayne St.
 Hamilton, E. D.
 2405 Florida Dr. (3)
 Harshman, L. P.
 2704 N. Clinton (3)
 Harvey, H. C. 1202 E. State (3)
 Hasewinkle, A. M. 1129 E. State (3)
 Hastings, Warren C. 811 Ewing St.

Hattendorf, A. P.
 725 Medical Center Bldg. (2)
 Havens, R. E.
 312 Medical Center Bldg.
 Hiatt, Russell L. Veterans Hospital
 Hoffman, A. F. 233 E. Jefferson
 Hoffmann, S. P.
 234 E. Maple Grove St.
 Howe, F. L. 1525 Oxford St.

J-K

Jackson, John F. 414 W. Rudisill
 Johnston, Richard M.
 312 Medical Center Bldg. (2)
 Jurgensen, W. T. 3415 Fairfield
 Karol, Herbert J.
 624 Medical Center Bldg.
 Kaufman, Julian
 702 Medical Center Bldg.
 Keck, Carleton A.
 2902 Fairfield Ave. (2)
 Kent, Richard N.
 731 Medical Center Bldg. (2)
 Kidder, O. T. Irene Byron Hosp.
 Kimbrough, Robert F.
 618 Medical Center Bldg. (2)
 Kleifgen, William A.
 617 W. Washington St.
 Kruse, E. H. 705 Lincoln Tr. (2)
 Kruse, Walter E.
 512 Medical Center Bldg. (2)

L

Ladig, D. S. 337 E. Berry (2)
 Land, Francis L.
 116 W. Rudisell Blvd.
 Lehner, J. J.
 323 Medical Center Bldg. (2)
 Leming, Ben L.
 1135 Lincoln Bank Bldg.
 Lenk, G. G. 2007 Maumee (4)
 Lloyd, Robert P. 717 Broadway
 Lohman, R. M.
 229 Medical Center Bldg. (2)
 Lorman, James G.
 520 Medical Center Bldg. (2)
 Loudermilk, Jack L.
 525 Medical Center Bldg. (2)
 Lyon, William C.
 2902 Fairfield Ave. (6)

M

Mackel, Frederick O.
 2301 Fairfield Ave.
 Manning, George 811 Ewing St.
 McArdle, E. G. 2201 S. Calhoun (5)
 McCallister, John W.
 424 Medical Center Bldg. (2)
 McCoy, R. R. 3701 S. Harrison (6)
 McDowell, G. A.
 215 Medical Center Bldg. (2)
 McEachern, Cecil G.
 701 Medical Center Bldg. (2)
 McFall, J. R. S. 1706 Sherman
 McKeeman, Donald H.
 633 W. Wayne St. (2)
 McKeeman, L. S.
 304 Medical Center Bldg. (2)
 McNairy, Donald J.
 710 Medical Center Bldg. (2)
 Mendenhall, Edgar
 208 Medical Center Bldg. (2)

ALLEN COUNTY**(Fort Wayne—Continued)**

Mensch, James R.
2506 Lower Huntington Road
Mercer, Samuel R.
710 Medical Center Bldg. (2)
Meyer, H. A. . . . 1030 W. Wayne (2)
Meyer, T. O.
228 Medical Center Bldg.
Michaelis, S. C. . . 2154 Fairfield (6)
Miller, C. G. . . . 229 W. Wayne (2)
Miller, H. Paul. . . 2809 Broadway
Miller, Mahlon F.
334 Medical Center Bldg. (2)
Miller, O. J. . . . 324 W. Berry (2)
Miller, R. H. . . . 511 W. Wayne (2)
Moats, C. F. . . . 4007 S. Wayne (6)
Moats, G. E. 615 E. Washington St.
Moeller, Victor C.
1244 W. Branning St.
Moravec, A. E. 705 Lincoln Tr. (2)
Mortenson, L. J.
214 Medical Center Bldg. (2)
Mueller, L. W. . . . 533 W. Wash.
Murdock, H. L.
521 Medical Center Bldg. (2)

N-O

Nahrwold, E. W.
417 Medical Center Bldg. (2)
Nill, J. H. 1024 S. Barr (2)
O'Rourke, C. . . . 604 W. Berry (2)
Oyer, J. H. . . . 2707½ S. Calhoun St.

P

Painter, Donald S.
222 Medical Center Bldg. (2)
Parker, C. B. . . . 1105 S. Harrison St.
Perrin, K. F. . . . 2701 S. Anthony St.
Perry, F. G. 2902 Fairfield (6)
Phillips, John F. 3418 S. Hanna St.
Pickett, Merle E.
312 Medical Center Bldg. (2)
Ponczek, Edward. . . 3930 Indiana
Pontius Edwin E. 4724 Bowser Ave.
Popp, Milton F.
610 Medical Center Bldg. (2)
Prentiss, Nelson H.
276 Central Bldg. (2)

Q-R

Rabson, S. M. . . . 730 W. Berry St.
Ranke, John W. Henry (S)
3112 Beaver Ave. (6)
Rawles, L. T. . . . 3131 Fairfield (6)
Ray, Herbert A. (S)
402 Medical Center Bldg. (2)
Rice, W. B. . . . 1101 E. Pontiac (5)
Rissing, W. J.
416 Medical Center Bldg. (2)
Rockey, N. A. . . . 1224 E. State (3)
Rodriguez, J. . . . 2902 S. Fairfield (6)
Roser, A. J. 617 W. Washington
Rossiter, D. L. . . . 103½ E. Pontiac
Rothberg, Maurice
625 W. Berry St.
Rothschild, C. J.
319 Medical Center Bldg. (2)

S

Sahlmann, H. . . . 1320 Broadway (2)
Salon, H. W. 535 W. Berry (2)
Salon, Nathan L. . . 604 W. Wayne
Sarver, Francis E. . 717 Broadway
Savage, A. R. . . . 302 W. Berry (2)

Schellhouse, Earl. . 1240 W. Main
Schlademan, Karl R.
516 Medical Center Bldg. (2)
Schlegel, Edward H. 1129 Maumee
Schmidt, Eugene E.
312 Medical Center Bldg. (2)
Schmoll, R. J. . . . 604 W. Berry St.
Schneider, L. H. . . 730 W. Berry St.
Schoen, Frederic L.
604 W. Wayne St.
Scoins, W. H. . . . 1301 S. Harrison
Scott, H. V. 2902 Fairfield (6)
Senseny, Eugene F.
116 W. Rudisell Blvd.
Senseny, Herbert
314 Medical Center Bldg. (2)
Sherwood, Clarence E.
Irene Byron Hosp.
Sherwood, J. V.
Irene Byron Hosp.
Shinabery, L. . . . 1850 Broadway (6)
Short, J. T. 2902 Fairfield (6)
Singer, Elmer C.
825 Oakdale Dr.
Smith, Philip L.
2902 Fairfield (6)
Snyderman, Sanford C.
629 Medical Center Bldg.
Somers, Gerald H.
2506 Lower Huntington Rd. (8)
Sparks, A. Jerome. . Veterans Hosp.
Stauffer, R. C.
618 Medical Center Bldg. (2)
Stellner, H. 324 W. Berry St.
Stier, Paul L. . . . 721 Broadway
Stoler, A. E. 278 Central Bldg.

T

Terrill, R. W. . . . 455 Lincoln Tr. (2)
Theye, Richard A.
1609 Columbia Dr.
Thimlar, J. W. . . . 602 E. Lewis (2)
Thompson, H. . . . Irene Byron Hosp.
Thornton, Walter E.
Lincoln Nat. Life Ins. Co.

W

Walker, Floyd B. . . 610 E. Pontiac
Warfield, C. H. . . 730 W. Berry St.
Weber, John R.
519 Medical Center Bldg.
Weber, Norbert
233 E. Jefferson St.
Welty, S. G. 2702½ S. Calhoun (5)
Wilkins, R. W. . . . 2902 Fairfield (6)
Williams, A. B. 3526 N. Wash. Rd.
Williams, A. H. . . 2902 Fairfield (6)
Wilson, Leslie . . . Veterans Hosp.
Wilson, R. B. 1207 S. Lafayette (2)
Worley, Ansel C.
317 Medical Center Bldg. (2)
Wright, Wm. C.
621 Medical Center Bldg. (2)
Wyatt, James L. III
336 W. Berry St.
Wyatt, J. L. II 233 E. Jefferson (2)

X-Y-Z

Zehr, Noah. . . . 301 W. Creighton (6)
Zweig, E. S. 344 W. Berry (2)
Emme, Richard W. Harlan
Cutshaw, James A. . . . Monroeville
Dahling, C. W. New Haven
Hoetzer, Eldore M. . . . New Haven
Smith, Grover A. New Haven
Smith, Richard B. New Haven

Stumpf, Edwin E. . . . New Haven
Emenhiser, Donald C.
R. R. 2, Woodburn
Moser, Edward (S)
Box 65, Woodburn
Draper, Merlin H.
231 E. Maderia Ave.,
Maderia Beach, Fla.
Havice, Jay F.
Box 56, Lake Lure, N. C.
Tennant, David L.
23 Broadmoore, Alexandria, La.

BARTHOLOMEW-BROWN COUNTIES**Columbus**

Adler, David L.
Bartholomew County Hospital
Beggs, Lowell F.
633 Washington St.
Davis, Marvin R.
814 Washington St.
Fisher, Walter S. . . . 422 9th St.
Hart, Robert B.
712 Washington St.
Hawes, James K. (S)
725 Washington St.
Hawes, Marvin E.
633 Washington St.
Henry, Alvin L. . . . 621 Franklin St.
Macy, George W.
718 Washington St.
Marr, Griffith. . . . 741 Washington St.
McCullough, Henry G. . . Columbus
Norton, Harold J.
911 Washington St.
O'Bryan, Richard B. 326 16th St.
Overshiner, Lyman
633 Washington St.
Reid, Robert M.
725 Washington St.
Ritteman, George W.
Bartholomew County Hospital
Rothing, Howard E.
Bartholomew County Hospital
Ryan, William J.
911 Washington St.
Schmitt, Richard K. . 423 Ninth St.
Sigmund, William B. . 522 7th St.
Teal, Dorothy Denzle
728 Franklin St.
Williams, Everett W.
725 Washington St.
Wissman, William L.
725 Washington St.
Wood, Elmer U. (S)
2012 Washington St.
Yoder, Dewey D.
725 Washington St.
Zaring, Byron K.
718 Washington St.
Dudding, Joseph E. Hope
Smith, Don C. Hope
Schneider, Kenneth. . . . Nashville
Elkins, James P.
Tripler Army Hosp., A.P.O. 438,
San Francisco, Calif.
McKnight, Robert D.
U. S. Army Hosp.,
Camp Atterbury
Nabbe, Philip M.
U. S. Army Hosp.,
Camp Atterbury
Wood, Hobart
U. S. Army Hosp.,
Camp Atterbury

BENTON COUNTY

Taylor, Wade H. Ambia
 Atkinson, Charles W. (S) . . . Boswell
 Leak, Robert Boswell
 Coddens, A. L. Earl Park
 Altier, William H. Fowler
 Fields, Don Fowler
 Turley, Verne L. Fowler
 McCabe, James E. (S) . . . Otterbein
 Smith, Charles G. Otterbein
 Scheurich, Virgil Oxford

BLACKFORD COUNTY

(See Delaware-Blackford)

BOONE COUNTY

Riley, Frank H. (S) . . . Jamestown
 Schaaf, Alvin D. Jamestown
 Beck, Herma A. Lebanon
 Coons, John D. Lebanon
 Coons, Ritchie Lebanon
 Headley, Lloyd M. Lebanon
 Honan, Paul R. Lebanon
 Kern, Clarence G. Lebanon
 Porter, Jack Lebanon
 Rainey, Everett A. (S) . . . Lebanon
 Spieth, William H. Lebanon
 Weddle, Charles O. Lebanon
 Wiseheart, Robert H. Lebanon
 Bassett, Clancy Thorntown
 Bassett, Margaret A. Thorntown
 Gregg, Edwin E. Thorntown
 Bailey, Lawrence S. Zionsville
 Harvey, Ralph J. Zionsville
 Lovett, Harvey Whitestown

BROWN COUNTY

(See Bartholomew-Brown)

CARROLL COUNTY

VanKirk, John R. Burlington
 Kennedy, Eva N. Camden
 Wise, Charles L. Camden
 Byrne, John M. Delphi
 Crampton, Charles C. (S) . . . Delphi
 Wagoner, George W. Delphi
 Wagoner, John R. Delphi
 Adams, Max R. Flora
 McLaughlin, James R. Flora
 Brown, Thomas
 2702 Albans St., Houston, Texas

CASS COUNTY

Dutchess, C. Toney Galveston

Logansport

Adamski, Michael 408 North St.
 Bailey, Earl W. 212 Fifth St.
 Ballard, Chas. A. 325½ E. Market
 Cooper, Thomas L. 408 North St.
 Davis, John C. Masonic Temple
 Ferguson, John T. State Hosp.
 Fitzgerald, Brice E.

Masonic Temple
 Hall, Bernard R. 415 North St.
 Hedde, Eugene L. 309 Seventh St.
 Hillis, Lowell J. 203 S. Third
 Hochhalter, M. 307 Barnes Bldg.
 Hogle, F. D. Logansport St. Hosp.
 Holloway, W. A. (S)
 200 Eel River Ave.

Jewell, Earl B. 3019 S. Penn St.
 Jones, J. Carl 422 North St

CASS COUNTY

(Logansport—Continued)

Killian, E. Camille
 211 S. Third St.
 Killian, Edgar W. 211 S. Third St.
 Landis, Charles State Hosp.
 Larson, John A. State Hosp.
 Lemon, H. K. State Hosp.
 Maxwell, John B. (S)
 1119 High St.

Morrical, Russell S. 212 Fifth St.
 Morrow, George W. State Hosp.
 Schenk, Foss 97 21st St.
 Shultz, Henry M. (S)
 412 Fourth St.

Slimp, Thomas E. 216 Ninth St.
 Stanton, Jas. J. 220 S. Sixth St.
 Stewart, Milton B. (S)
 1515 E. Broadway

Terfinger, Fred W. (S)
 422 North St.

Travis, Julius C. State Hosp.
 Viney, Charles L. Masonic Temple
 Wilson, Paul H. 422 North St.
 Winter, Donald K. 422 North St.

Newcomb, Wm. K. Royal Center
 Planagan, Estle P. Walton
 Lybrook, Daniel E. Young America

CLARK COUNTY

Bottorff, David Charlestown
 Davis, Claude E. Charlestown
 Eckles, Donald H. Charlestown
 Goodman, Eli Charlestown
 Patterson, Cecil Charlestown
 Willner, Alan Clarksville
 Greene, William R. Henryville

Jeffersonville

Adair, Samuel L. 201 E. Market St.
 Baldwin, J. H. (S) 425 Meigs Ave.
 Bruner, Ralph W. 437 Spring St.
 Buckley, Ernest P.

14 Blanche Terrace
 Buehler, George M. Jeffersonville
 Carlberg, Dale 442 Spring St.
 Carney, Joel T. 344 Spring St.
 Clark, William B., Jr.

205 Lindley Bldg.
 Dare, Lee A. 209 E. Maple St.
 Forsee, Norman E. 456 Spring St.
 Huoni, John S. 105 W. Maple St.
 Isler, Nathaniel C. 521 Spring St.
 Reeder, Henry H. 140 High St.
 Roby, A. L. 201 E. Market
 Varble, William M. (S) . . . Best Bldg.
 Weems, Mallory P.

203 Lindley Bldg.
 Wilber, Harold 437 Spring St.
 Witt, William R. Pfifer Bldg.

Regan, George L. Sellersburg
 Sturgis, D. G. Sellersburg
 Vandervert, Arthur C. Sellersburg
 Bizer, Mier A.

Christ Hosp., Cincinnati, O.

CLAY COUNTY

Maurer, J. Frank Brazil
 Maurer, Robert M. Brazil
 Palm, John M. Brazil
 Shattuck, John C. Brazil
 Weaver, Timothy M. (S) . . . Brazil
 Webster, Robert K. Brazil
 Wood, Opal L. Brazil
 Moon, Charles E. Center Point

Bond, Walter C. Clay City
 Glosson, Jack R. Clay City
 Ward, Harry H. (S) Coalmont

CLINTON COUNTY**Frankfort**

Applegate, A. E. 51 E. Walnut St.
 Beardsley, Frank A.

51 S. Jackson St.
 Beardsley, John 51 S. Jackson St.
 Burroughs, Carroll A.
 59 S. Main St.

Carrel, Francis E.
 207½ N. Jackson St.

Dykhuizen, Theodore A.

59 S. Main St.
 Erdel, Milton W. 59 S. Main St.
 Hammersley, Geo. K.

361 E. Clinton St.

Hedgcock, Robert A.

205 E. Clinton St.

Holmes, Claude, Sr. 9½ W. Clinton

Jones, William W.

9½ W. Clinton St.

Kneidel John H.

Clinton County Hospital

Stout, Harry T., Jr.

361 E. Clinton St.

Van Kirk, John A.

204 W. Washington St.

Van Kirk, Paul P.

204 W. Washington St.

Work, Bruce A. 47½ S. Jackson St.

Carlyle, Ivan E. Michigantown

Combs, Nelson B. Mulberry

Kent, John A. (S) Mulberry

Grove, Robert H. Rossville

Ketcham, John S. Rossville

Compton, Charles B.

4251 7th Ave., Los Angeles, Cal.

Holmes, John L.

A.P.O. 942 c/o P.M.,

Seattle, Wash.

CRAWFORD COUNTY

(See Harrison-Crawford)

DAVIESS-MARTIN COUNTIES

Rohrer, James R. Elnora
 Chattin, Robert E. Loogootee
 Gilkison, Wm. L. (S) Loogootee
 Lett, Emory B. Loogootee
 McCracken, Jacob O. Montgomery
 Sears, Don Odon
 Coleman, H. G. Odon
 Gilkison, William L. (S) . . . Shoals
 Maschmeyer, Robert H. . . . Shoals

Washington

Arthur, Nora M. R. R. 4
 Blazey, Arthur G. Williams Bldg.
 Burress, Bert O. (S)

State Bank Bldg.

Chattin, Vance J. 514 E. Main St.

Farris, John J. 514 E. Main St.

Fox, C. Philip

305 Peoples Bank Bldg.

Lindsay, Hamlin B.

511 East Main St.

Lloyd, Claude A. 107 N.E. 2nd St.

McKittrick, Jack

Peoples Bank Bldg.

McNaughton, L. M.

400 E. Hebron St.

Norton, Horace 511 E. Hebron St.

Rang, Arthur A. 211 N.E. 9th St.

DAVIESS-MARTIN COUNTIES

(Washington—Continued)

Rang, Robert H. . . . 214 N.E. 9th St.
 Schafer, Wm. C. . . . 1312 Bedford Rd.
 Schroeder, Henry . . . 101 N.E. 1st St.
 Seat, Marshall H. . . .

101 N. E. 1st St.
 Shields, Harry A. . . . 106 E. Main St.
 Smoot, Emory B. . . . 507 E. Main St.

DEARBORN-OHIO COUNTIES

Baker, Leslie M.Aurora
 Jackson, John K.Aurora
 Olcott, Charles W.Aurora
 Stewart, Omer H.Aurora
 Treon, James F.Aurora
 McNeely, Matthew J. . . . Dillsboro
 Elliott, John C.Guilford
 Fagaly, William J. . . . Lawrenceburg
 Houston, Fred D. . . . Lawrenceburg
 Pfeifer, James M. . . . Lawrenceburg
 Streck, Francis A. . . . Lawrenceburg
 Vail, George A. . . . Lawrenceburg
 Fessler, Gordon S. . . . Rising Sun
 Manley, Charles N. . . . Rising Sun

DECATUR COUNTY

Tremain, Milton A. (S) . . . Adams
 Acher, Robert P. . . . Greensburg
 Blemker, Russell H. . . . Greensburg
 Callaghan, Winship C. . . Greensburg
 Dickson, Dale D. . . . Greensburg
 McKee, Harley S. (S) . . . Greensburg
 Miller, James C. . . . Greensburg
 Morrison, James T. . . . Greensburg
 Overpeck, Charles . . . Greensburg
 Sallee, William T. . . . Greensburg
 Harkcom, Harry E. . . . St. Paul

DEKALB COUNTY

Covell, Harry M.Auburn
 Geisinger, Lewis N. (S) . . Auburn
 Hines, Archie V.Auburn
 Hippensteel, Harland V. . . Auburn
 Nugen, HaroldAuburn
 Rogers, Evered E.Auburn
 Sanders, Jesse A.Auburn
 Souder, Bonnell M.Auburn
 Thill, Leonard J.Auburn
 Wills, MaxAuburn
 Hathaway, Clayton B. . . . Butler
 Weirich, Charles I.Butler
 Jinnings, Loren E.Garrett
 Kantzer, Floyd B.Garrett
 Nason, Robert A.Garrett
 Novy, Charles A.Garrett
 Reynolds, D. Monroe (S) . . Garrett
 Reynolds, Russell P. . . . Garrett
 Coleman, Floyd B.Waterloo
 Showalter, John P.Waterloo
 Mettler, Don C.

916 Duncan St., Ann Arbor, Mich.
 Van Nest, Willard A. . . . New Smyrna Beach, Fla.

DELAWARE-BLACKFORD COUNTIES

Brown, Stewart D.Albany
 Puterbaugh, Karl E. . . . Albany
 Hurley, John R.Daleville
 Tucker, Oral A.Daleville
 Ames, George F. (S)Eaton
 Ko, RichardEaton
 Downard, Leland F.Gaston
 Langsdon, Fred R.Gaston
 Dando, G. H. (S) . . . Hartford City

Dodds, Jas. U.Hartford City
 Jackson, Dean B. . . . Hartford City
 Owsley, Guy A. . . . Hartford City
 Weldy, Bryce P. . . . Hartford City
 Werry, Leslie E. . . . Hartford City
 Wierzalis, Edward F. . . .

Hartford City
 Burns, Paul E.Montpelier
 Douglas, William T. . . . Montpelier
 Taylor, James A. (S) . . Montpelier

Muncie

Adams, W. B. . . . Ball Mem. Hosp.
 Alvey, C. R. . . .

402 W. Washington St.
 Ball, Clay A.303 W. Adams
 Ball, Phillip

420 W. Washington St.
 Bibler, Henry E. . . . 311 W. Adams
 Botkin, C. G.508 W. Jackson
 Botkin, Thos.417 N. Martin St.
 Brown, Leland G. . . .

206 S. High St.
 Brown, Thomas M. . . .

206 S. High St.
 Brunoehler, Carl J. . . .

403 N. High St.
 Burwell, Stanley W. . . .

424 W. Jackson St.
 Butterfield, R. M. . . . 315 W. Jackson
 Chereck, Edward J. . . .

100 N. Cherry St.
 Clauser, E. H. M. . . . 315 S. Jefferson
 Clevenger, J. H. . . . 424 W. Jackson
 Covalt, W. E. . . . 305 West. Res. Bldg.
 Cure, E. T.105 West. Res. Bldg.
 Davis, Edgar C. . . . 107 Plaza Bldg.
 Deutsch, Wm. . . . 309 Johnson Bldg.
 Dunn, F. W.118 S. Franklin
 Fair, Herbert D. (S) . . .

201 Alameda Ave.
 Funk, John W.217 W. Charles
 Galliher, M. J.115 S. Liberty
 Garling, L. C. . . . 420 W. Washington
 Geckler, Charles E. . . .

Muncie Clinical Lab.
 Gill, Thos. A.808 W. Jackson
 Greiber, M. F. . . . 420 W. Washington
 Gustafson, Milton . . . 808 W. Jackson
 Hall, Orville A. . . . 514 Wysor Bldg.
 Hayes, T. R.210 S. High
 Henderson, R. A. . . . 806 W. Main
 High, Ralph L. . . . 420 W. Washington
 Hill, Howard E. . . . 402 W. Jackson
 Hill, Robert E. . . . 215 W. Jackson
 Hostetter, Irwin S. . . 115 N. Cherry
 Hurley, Anson G. . . . 110 N. Cherry
 Imhof, Jos. D. . . . 206 West. Res. Bldg.
 Kammer, G. C. . . . 420 W. Washington
 Kammer, W. F. . . . 420 W. Washington
 Kemper, A. T. (S) . . . 112 W. Adams
 Kern, C. B. (S) . . . 715 E. Washington
 Kirshman, F. E. . . . 211 S. High
 Kuder, Howard V. . . .

420 W. Washington
 LaDuron, J. F. . . . 517 S. Liberty
 McClintock, James A. . . .

316 W. Adams
 McCoy, George E. . . 417 Wysor Bldg.
 McDowell, Fletcher W. . .

315 S. Jefferson
 McMichael, R. M. . . 324 W. Adams
 Molloy, W. J. (S) . . .

619 E. Charles St.
 Montgomery, Lall G. . . .

Ball Memorial Hospital
 Moore, Thos. C. . . . 110 N. Cherry
 Moore, Wm. C. . . . 110 N. Cherry

DELAWARE-BLACKFORD COUNTIES

(Muncie—Continued)

Morris, Jean W. . . . 247 Johnson Bldg.
 Nelson, Harold E. . . .

Ball Memorial Hospital
 Owens, R. R. . . . 406 West. Res. Bldg.
 Owens, T. R. . . . 202 West. Res. Bldg.
 Peacock, Robert C. . . .

205 West. Res. Bldg.
 Quick, Wm. J. . . . 314 E. Washington
 Rettig, Arthur C. . . . 314 W. Jackson
 Rivers, Glynn A. . . . 806 W. Jackson
 Saperstein, Morris

2327 S. Madison St.
 Schulhof, M. G. . . . 418 W. Wash.
 Silver, Richard A. . . . 9 Parkway
 Smith, Jas. S.501 Kirby
 Spurgeon, O. E. . . . 310 E. Washington
 Stanley, John R. . . .

401 W. Jackson St.
 Starks, William O. . . .

420 W. Washington St.
 Stocking, B. W. . . . Ball Mem. Hosp.
 Stout, Francis E. . . .

303 Western Res. Bldg.
 Tindal, E. F. (S) . . . 214 Wysor Bldg.
 Tomlin, Hugh M. . . .

420 W. Washington
 Turner, Robt. D. . . . 217 S. Liberty
 Venis, K. N.108 N. Liberty
 Vlaskamp, E. M. . . . 401 W. Main
 Williams, J. H. . . . 306 E. Jackson
 Wood, Amelia T. . . . 2004 Petty Rd.
 Young, G. S.316 W. Jackson

Hummell, Paul.Oakville
 Moss, Mavor J.Yorktown
 Craigmile, Thomas K. . . .

V. A. Hosp., Hines, Ill.
 Mahuron, Boyd L. . . .

Miami Valley Hospital,
 Dayton 9, Ohio
 Sneed, William Rockford, Ill.

DUBOIS COUNTY

Backer, Henry G.Ferdinand
 Amini, SohrabHuntingburg
 Bretz, John M.Huntingburg
 Bretz, W. D.Huntingburg
 Lukemeyer, L. C. (S) . . .

Huntingburg
 Steinkamp, Emil F. . . . Huntingburg
 Stork, Harvey K.Huntingburg
 Williams, Charles E. . . . Huntingburg
 Williams, F. P.Huntingburg
 Blessinger, Paul J.Jasper
 Greenburg, Rolland Jasper
 Heck, Martin C.Jasper
 Held, George A.Jasper
 Klamer, Charles H.Jasper
 Lukemeyer, George T. . . . Jasper
 Lukemeyer, St. John Jasper
 Ploetner, Edward J.Jasper
 Salb, Leo A.Jasper
 Wagner, Arthur L.Jasper

ELKHART COUNTY

Horswell, Richard G. . . . Bristol
 Neidballa, Edward G. . . . Bristol

Elkhart

Arlook, Theo. D. . . . 912 W. Franklin
 Bender, Robt. L. . . . 411 S. Third
 Billings, Elmer R. . . 115 S. Third St.
 Bloom, Geo. R.506 S. Second
 Bolin, Robt. S.209 S. Second

ELKHART COUNTY (Elkhart—Continued)

Bowdoin, Geo. E. 515 S. Second
Compton, W. A. 2225 Greenleaf
Conklin, R. L. 1906 E. Jackson
Cormican, H. L. 316 S. Fourth
Crandall, L. A. Ames Laboratories
DeDario, L. M. 123 W. Marion
Dovey, Edward G. 405 S. Second St.

Elliott, Lloyd A. 405 S. Second
Elliott, Thomas A. 405 S. Second St.

Fleming, C. F. 121 W. Marion
Fleming, Justus M. 123 W. Marion
Hull, Arthur W. 506 S. Second
Kintner, B. E. 132 Monger Bldg.
Kistner, A. W. 123 W. Marion
Koehler, Elmer G. Monger Bldg.
Leasure, Kenneth 903 W. Franklin St.

Logan, Richard S. Monger Bldg.
Lundt, Milo O. 521 S. Second
Markel, Ivan J. 215 W. Franklin
McArt, Bruce A. 209 Equity Bldg.
McKee, H. N. (S) 319 Monger Bldg.

Mendez, Carlos. 116 W. Marion
Miller, Galen R. 903 W. Franklin St.

Miller, H. A., Jr. 314 W. Jackson
Miller, Samuel T. 506 S. Second
Mininger, E. P. 413 W. Franklin
Mishkin, Irving. 209 S. Second
Norris, Allen A. (S) 208 W. Marion

Paff, Wm. A. 515 S. Second
Paine, Geo. E. 329 Meisner Ave.
Pancost, V. K. 415 S. Second
Patrick, Glenn B. 427 S. Second
Rohr, Joseph H. Ames Laboratories

Rupe, Lloyd O. Equity Bldg.
Schlosser, H. C. 116 W. Marion
Sears, M. M. (S) 304 Equity Bldg.
Spray, Page E. 405 S. Second
Stauffer, W. A. (S) 214 Equity Bldg.

Stout, R. B. 1501 Greenleaf Blvd.
Stubbins, Wm. M. 412 S. Second
Swank, L. F. 315 Equity Bldg.
Swihart, H. R. 124 W. Marion St.
Swihart, L. F. 214 W. Marion
Todd, David D. 2001 E. Jackson Blvd.

Wilson, O. E. 217 N. Main
Work, Jas. A., Jr. 412 S. Second

Goshen

Amstutz, H. C. 521 S. Main
Bartholomew, M. L. 107 S. Fifth
Bender, C. K. 115 E. Washington
Bigler, Frederick W. 314 S. 5th St.

Bosler, Howard A. Waterford Mills, Mail Goshen
Chandler, Leon H. 412 S. 5th St.
Eby, Ida L. 131 S. Main
Freeman, F. M. 109 W. Wash.
Hostetler, C. M. 304 E. Lincoln
Kelly, Wm. R. 210 N. Main
Kinzie, M. Dale. Shoots Bldg.
Martin, Floyd S. 127 E. Lincoln
Miller, M. E. Spohn Bldg.
Simmons, L. H. 208 E. Lincoln
Turner, John P. Shoots Bldg.
Wagner, David G. 307 S. 7th St.

ELKHART COUNTY (Goshen—Continued)

Westfall, Geo. S. 214 E. Lincoln
Yoder, Albert C. 113 S. Fifth
Young, Ralph H. 113 E. Madison

Norris, Ernest B. Middlebury
Teters, Melvin S. Middlebury
Fleetwood, R. A. Nappanee
Kendall, Forest M. Nappanee
Price, Douglas W. Nappanee
Slabaugh, Jancey S. (S) Nappanee
Roose, Lisle W. Nappanee
De Fries, John. New Paris
Stuckman, E. D. (S) New Paris
Abel, Robert Wakarusa
Amick, Charles L. Wakarusa
Hannah, Jack W. Wakarusa
Dewey, Fred N. (S) 1216 River Rd., Maumee, Ohio

Yoder, C. Richard 1601 W. Broad St., Columbus, O.

FAYETTE-FRANKLIN COUNTIES

Foreman, Walter A. Brookville
Peters, Elmer Brookville
Seal, Perry F. Brookville
Smith, Herbert N. Brookville

Connersville

Dale, Maxwell H. 818 Grand
Ellis, Geo. M., Jr. 108 E. Tenth
Entner, Charles L. 117 E. Sixth
Fruth, Rodney B. 634 Eastern
Fruth, Virgil J. 634 Eastern
Gordin, Stanley B. R. D. 3
Gregg, Albert F. 124 E. Sixth
Joest, Charles O. 1533 Eastern Ave., No. 1

Kemp, William A. 122 W. Seventh
Lockhart, Jack M. 520 Eastern
Mountain, Francis B. 930 Central
Neukamp, Frank H. American Central Mfg. Co.

Smelser, Herman W. 823 Central
Watterson, Gerald T. 1910 Virginia Ave.

Poston, C. L. R. R. 2, Laurel

Phillips, William R. (S) Glenwood

FLOYD COUNTY

Engleman, Harry K. Georgetown

New Albany

Allen, Frederick K. 1207 E. Spring St.
Baker, Avey M. 811 E. Spring
Baxter, Jas. W. 1201 E. Spring
Baxter, Saml. M. 1201 E. Spring
Briscoe, C. E. (S) 1413 E. Spring
Brown, Kenneth H. 410 E. Spring
Byrn, Howard W. 415 Elsby Bldg.
Davis, Parvin M. 601 E. Spring
Day, George H. 1252 Vincennes
Edwards, William F. Floyd County Bank Bldg.

Garner, Wm. H. 919 E. Spring
Gentile, John P. 101 Adams St.
Hauss, A. P. 212 Elsby Bldg.
Hess, Paul P. Floyd Co. Bank Bldg.

FLOYD COUNTY (New Albany—Continued)

Higgins, John R. 624 E. Spring St.
LaFollette, Robt. E. 500 Spring
McCullough, J. Y. 624 E. Spring
Murphy, Edgar W. 1824 State
Pace, Jerome V. Silvercrest San.
Paris, John M. 602 E. Spring
Pierce, Gene S. R. R. 21
Pierson, Percy R. 203 Liberty State Bank Bldg.

Polhemus, G. I. 1610 E. Spring
Robertson, A. N. 820 E. Spring
Shacklett, Henry B. (S) 117 E. Spring St.

Sloan, Herbert. 1207 E. Spring
Streepey, J. I. 1102 E. Spring
Tyler, Frank T. 420 Vincennes
Voyles, Harry E. 216 Elsby Bldg.
Weaver, Wm. W. 1104 E. Spring
Wohlfeld, Gerald. Silvercrest San.
Wolfe, Nelson. 1117 E. Spring
Worley, Henry L. 1104 E. Spring St.

FOUNTAIN-WARREN COUNTIES

Fisher, John E. Attica
Freed, Carl A. Attica
Freed, James C. Attica
Maris, Lee J. Attica
Johnson, Earl E. Covington
Stephens, Lowell R. Covington
Suzuki, T. T. Covington
Priebe, Fred H. Hillsboro
Smith, Byron J. Kingman
Himebaugh, G. J. Veedersburg
McCorr, Carl B. Veedersburg
Lefforge, E. Everett. Veedersburg
Rusk, Hubert M. Wallace
Nelson, Carl A. West Lebanon
Crain, James W. Williamsport

FULTON COUNTY

Herrick, Charles L. Akron
Miller, Virgil Akron
Dielman, Franklin C. Fulton
Kelsey, Lawrence E. Kewanna
Kraning, Kenneth K. Kewanna
Glackman, John C. Rochester
Herendeen, Elbie V. Rochester
Knotts, Slater Rochester
Richardson, Chas. L. Rochester
Rowe, Howard H. Rochester
Stinson, Arthur E. Rochester
Stinson, Dean K. Rochester

GIBSON COUNTY

Geick, Raymond G. Fort Branch
Hollis, Walter. Fort Branch
Marchand, Austin F. Haubstadt
Marchand, Edwin V. Haubstadt
Pettijean, Harold G. Haubstadt
Arthur, Hamilton M. (S) Hazelton
Chappell, Harold R. Oakland City

Ropp, Eldon R. Oakland City
Turner, Maurice. Oakland City
Wood, Russell W. Oakland City
Geller, Samuel Owensville
Strickland, Karl S. Owensville

GIBSON COUNTY

(Continued)

Alexander, Harry H. . . . Princeton
 Carpentier, Harry F. . . . Princeton
 Folk, John K. . . . Princeton
 Graves, Orville M. . . . Princeton
 Hollingsworth, M. P. (S) . . . Princeton
 McCarty, Virgil Princeton
 McElroy, Robert S. Princeton
 Miller, Charles A. (S) . . . Princeton
 Morris, W. F. (S) Princeton
 Peck, James F. Princeton
 Rhodes, Amos H. (S) . . . Princeton
 Weitzel, Roland Princeton

GRANT COUNTY

Grant, M. Arthur Fairmount
 Henley, Glenn (S) Fairmount
 King, Dale S. Fairmount
 Garrison, Leon J. Gas City
 Koontz, William A. Gas City
 Baskett, Russell J. Jonesboro

Marion

Abell, Chas. F.
 321 Marion Natl. Bk. Bldg.
 Alderfer, Henry
 131 N. Washington St.
 Ayres, Wendell W. . . 302 Glass Blk.
 Bates, George
 131 N. Washington St.
 Bloom, Asa W. 724 W. Third
 Boyer, Grace M. 313 Iroquois Bldg.
 Braunlin, Robert F.
 718 Marion Nat. Bank Bldg.
 Braunlin, William H.
 718 Marion Nat. Bank Bldg.
 Brown, Robert M.
 522 Marion Nat. Bank Bldg.
 Burge, A. D. (S)
 204 Odd Fellows Bldg.
 Comeau, Wm. J.

Marion General Hospital
 Currie, Robert W. 413 Glass Block
 Daniels, Erle O.
 708 Marion Nat. Bank Bldg.
 Daniels, Geo. R. . . . 324 Glass Blk.
 Davis, Joseph B.
 131 N. Washington St.
 Davis, Merrill S.
 131 N. Washington St.
 Davis, Richard
 131 N. Washington St.
 Diamond, Leo L.
 413 Marion Nat. Bank Bldg.
 Fisher, Henry 1502 S. Wash.
 Ganz, Max 930 S. Adams
 Ginsberg, S. T. . . . Veterans Hosp.
 Gustafson, Carl J.

Veterans Hospital

Hummel, Russel M.
 317 Marion Nat. Bank Bldg.
 Jarrett, John C.
 131 N. Washington St.
 Lavengood, R. W. . . 225 Glass Blk.
 Long, Max R. 803 S. Boots
 Love, V. Logan
 131 N. Washington St.

McIlwain, Eleanor E. . . 107 E. 31st
 McIlwain, Robt. E. . . . 107 E. 31st
 Miller, H. Allison. 320 Glass Blk.
 Mintz, Alfred M. 1016 Euclid Ave.
 Powell, J. Paxton. . . 309 Glass Blk.
 Renbarger, L. L. . . . 1531 W. Second
 Rhorer, John G. . . . 201 S. D St.

GRANT COUNTY

(Marion—Continued)

Schimmelpfennig, Robert J.
 131 N. Washington St.
 Simmons, Fredk. H.
 520 Whites Ave.
 Skomp, C. E. Marion Gen. Hosp.
 Warren, Carroll B.
 313 S. Nebraska
 Weinberg, Samuel . . 318 Glass Blk.
 Wicker, Eugene H.
 Marion General Hospital
 Woodbury, John W.
 131 N. Washington St.
 Young, Robt. G. . . . 2927 S. Wash.

King, Peter C. Swayzee
 Taylor, Everett C. . . . Upland
 Rifner, E. S. Van Buren

GREENE COUNTY

Graf, Jerome A. Bloomfield
 Mount, Mathias S. . . . Bloomfield
 Turner, Harold B. . . . Bloomfield
 Turner, Jack J. Bloomfield
 Van Sandt, Frank A. (S)

Bloomfield
 Porter, Carl M. Jasonville
 Rotman, Harry G. . . . Jasonville
 Rotman, Sam I. Jasonville
 Bailey, Edwin B. Linton
 Broshears, Kenneth . . . Linton
 Craft, William F. Linton
 Porter, George C. (S) . . Linton
 Raney, Ben B. Linton
 Tomak, Milton E. Linton
 Woner, John W. Linton
 Hamilton, M. Luther . . Newberry
 Fender, Asa H. Worthington
 Moses, George E. . . . Worthington
 Moses, Robert E. . . . Worthington

HAMILTON COUNTY

Hicks, Joseph (S) Arcadia
 Rodenbeck, Frank Arcadia
 McDaniel, Franklin P. . . Atlanta
 Donahue, Claude M. . . . Carmel
 Havens, Oscar Cicero
 Tomlinson, C. H. (S) . . Cicero
 Ambrose, Jesse C. . . . Noblesville
 Campbell, Sam W. . . . Noblesville
 Harris, Robert F. . . . Noblesville
 Hash, John S. Noblesville
 Hooke, Samuel W. . . . Noblesville
 Kraft, Haldon C. . . . Noblesville
 Shanks, Ray Noblesville
 Shonk, Harold W. . . . Noblesville
 Southard, Carl B. . . . Noblesville
 Thayer, Jos. O. R.R. 1, Noblesville
 Griffith, James W. . . . Sheridan
 Newby, Alonzo C. . . . Sheridan
 Newby, Eugene Sheridan
 Reck, John L. Sheridan
 Connoy, Andrew F. . . . Westfield
 Connoy, Leo F. Westfield

HANCOCK COUNTY

Scott, Robert S. Charlottesville
 Ferrell, Mars B. Fortville
 Manifold, Harold M. . . Fortville
 Navin, Hugh K. Fortville
 Allen, Joseph L. (S) . . Greenfield
 Beeson, Wilbur Greenfield
 Endicott, Wayne Greenfield

Gibbs, Charles M. (S) . . Greenfield
 Gill, Dee D. Greenfield
 Henn, R. Anthony Greenfield
 Hunter, Donn Greenfield
 Kinneman, Robert E. . . Greenfield
 Vingus, Bronie Greenfield
 Woods, James R., Jr. . . Greenfield
 Larrabee, Wm. H. (S)

New Palestine

Pierson, Thos. A. . . . New Palestine
 Kuhn, Robert W. Wilkinson
 Titus, Charles R. (S) . . Wilkinson

HARRISON-CRAWFORD COUNTY

Amy, William E. Corydon
 Blessinger, Louis H. . . . Corydon
 Brockman, Wilfred Corydon
 Dillman, Carl E. Corydon
 Baker, Guy D. Crandall
 Gobbel, N. E. English
 Benz, Jesse Marengo
 Lynch, O. R. Marengo
 Mathys, Alfred Mauckport
 Neely, Alonzo S. . . . New Middletown
 Johnson, J. M. Palmyra

HENDRICKS COUNTY

Foltz, Lloyd E. Brownsburg
 Scudder, Arthur N. . . . Brownsburg
 Ellett, John, Jr. Coatesville
 Elliott, Paul W. Danville
 Frantz, Mount E. Danville
 Koch, Elmer L. Danville
 Terry, Lloyd Danville
 Ellis, Lyman H. Lizton
 Wiseheart, O. H. (S) . . North Salem
 Scamahorn, Malcolm O. . . Pittsboro
 Scamahorn, Oscar T. . . . Pittsboro
 Aiken, Milo M. Plainfield
 Cohen, Irving Plainfield
 Johnston, Alan Plainfield
 Stafford, James C. . . . Plainfield
 Stafford, Wm. C. . . . Plainfield
 Walker, Jack Plainfield

HENRY COUNTY

Call, Earle B. Knightstown
 Dreyer, Ralph W. . . . Knightstown
 Matychowiak, Francis

Knightstown

Wiatt, Leonard Knightstown
 Scheetz, Marion R. . . . Lewisville
 Drago, Farrol Middletown
 Hammer, Jay W. . . . Middletown
 Stauffer, George E. . . . Mooreland
 Marshall, Lloyd C. . . . Mt. Summit

New Castle

Amos, Robert L. . . . 213 Burr Bldg.
 Bitler, Clyde C. . . . 1319 Church
 Bledsoe, James G. . . . 319 S. 14th
 Burnett, Arthur B. 310 Burr Bldg.
 Canaday, Clifford E. (S)

1411 Church
 Craig, Alexander F. R. F. D. No. 2
 Davies, Robert . . . 1319 Church St.
 Fincher, Robert C.

Ind. Village for Epileptics
 Fisher, John E. . . . 409 Burr Bldg.
 Foster, Ray T. Chrysler Corp.
 Harrison, B. L. 118 Jennings Bldg.
 Heilman, William C. . 1319 Church
 Hill, Kenneth G. . . . 1319 Church

HENRY COUNTY

(New Castle—Continued)

Iterman, George E. . . . 1319 Church
Kennedy, Walter U. . . . 214 S. 14th
Life, Homer L. . . . 101 S. 11th St.
McDonald, Frank C. . . . 527 S. Main St.

McElroy, James S. . . . 1319 Church
Saint, William . . . 1319 Church St.
Smith, Robert A. . . . 1229 Lincoln Ave.
Stout, Walter M. . . . 1319 Church
Thorne, Charles E. . . . 200 N. 12th
Tully, John A. (S) . . . 502 S. Main
Vivian, Donald E.

Henry County Hospital
Wiggins, Dulanian S. (S) . . . 1222½ Race

Wilson, Ralph (S) Shirley
Robertson, William S. . . . Spiceland

HOWARD COUNTY

Denton, Larkin D. Greentown
Shoup, Homer B. Greentown

Kokomo

Adams, Charles J. 618 Armstrong Landon Bldg.
Alward, John H. 401 W. Walnut St.

Ault, Carl H. 421 W. North St.
Boughman, Joe D. 322 Armstrong-Landon Bldg.

Bowers, C. C. 210 W. Mulberry
Bowers, Garvey B. . . . 210 W. Mulberry
Bowers, John A. . . . 210 W. Mulberry
Bruegge, Theodore J. . . . 630 Armstrong-Landon Bldg.

Clarke, Elton R. . . . 304 W. Taylor St.
Conley, Thomas M. . . . 520 Union Bank Bldg.

Craig, Reuben A. . . . 608 Armstrong-Landon Bldg.
Craig, Reuben 610 Armstrong-Landon Bldg.

Crawford, Theo. R. . . . 416 W. Sycamore
Cuthbert, Fredk. S. (S) . . . 211 E. Jefferson

Earl, Max M. 409 W. Taylor
Ferry, P. W. . . . 406 Union Bk. Bldg.
Golper, Marvin N. St. Joseph Mem. Hosp.

Good, Richard P. . . . 308 Armstrong-Landon Bldg.
Halfast, Richd. W. . . . 214 E. Mulberry
Hutto, William H. . . . 408 Armstrong-Landon Bldg.

Jewell, George M. . . . 508 Armstrong-Landon Bldg.
Knepple, LaMarr R. (S) . . . 325½ N. Main

Lung, Bruce D. . . . 410 Union Bk. Bldg.
McIndoo, Ralph E. . . . 304 W. Walnut
Meiner, Joseph A. . . . 911 S. Main
Morrison, William R. . . . 504 Union Bank Bldg.

Murray, Ernest C. . . . 207 E. Mulberry St.
Paris, Durward W. . . . 614 Armstrong-Landon Bldg.

Phares, Robt. W. . . . 905 W. Mulberry
Ramey, John W. . . . 107½ S. Union
Rhorer, Herbt. M. . . . 210 W. Mulberry
Rudicel, Max. . . . 1604 Kingston Rd.

HOWARD COUNTY

(Kokomo—Continued)

Schwartz, Frederick C. . . . 518 Armstrong-Landon Bldg.
Shenk, Earl M. . . . 208½ N. Main
Smith, Gloster J. . . . 105½ E. Sycamore
Sorenson, Raymond 522 Armstrong-Landon Bldg.
Spangler, Jesse S. . . . 215 E. Taylor

Evans, Robert M. Russiaville

HUNTINGTON COUNTY**Huntington**

Brubaker, Harold S. . . . 42 W. Park Dr.
Casey, Stanley M. . . . 408 E. Market
Clunie, Wm. A. . . . 323 W. Park Dr.
Cope, Stanton E. . . . 1022 N. Jefferson
Erehart, Mark G. . . . 232 W. Market
Eviston, John B. . . . 34 E. Wash.
Galbreath, Russell S. . . . 16 W. Wash.
Gray, Paul M. . . . 340 E. Market
Grayston, W. S. (S) . . . 303 E. Market
James, Thomas, Jr. . . . 48 E. Franklin
Johnston, Robt. G. . . . 339 E. Market
Marks, Howard H. . . . 248 W. Park
Meiser, Robt. D. . . . 612 N. Jefferson
Mitman, Floyd B. . . . 210 W. Park
Nie, Grover M. . . . 220 W. Park Dr.
Omstead, T. W. . . . 244 E. Washington
Ware, James R. . . . 48 E. Franklin

Woods, Halden C. Markle
Bennett, J. B. Warren
Black, C. S. Warren
Smith, Lucian Warren

JACKSON COUNTY

Cummings, David J. . . . Brownstown
Gillespie, Garland R. . . . Brownstown
Shields, Jack E. . . . Brownstown
Adair, William K. . . . Crothersville
Bard, Frank B. . . . Crothersville
Scharbrough, William . . . Medora
Black, Joe M. Seymour
Day, William D. C. . . . Seymour
Elsner, Lawrence W. . . . Seymour
Gillespie, Charles E. (S) . . . Seymour
Graessle, Harold P. . . . Seymour
Kamman, Geo. H. (S) . . . Seymour
Martin, Guy Seymour
Miller, Harold E. Seymour
Osterman, Louis H. . . . Seymour
Ripley, John W. Seymour
Shortridge, Wilbur H. . . . Seymour
Wiethoff, Clifford A. . . . Seymour

**JASPER-NEWTON
COUNTIES**

Pippenger, Wayne G. . . . Brook
Ockermann, Kenneth R. . . DeMotte
Smith, Marsh H. Goodland
Jacobs, George C. Kentland
Mathews, Wilbur C. Kentland
VanKirk, George H. Kentland
Yegerlehner, Roscoe S. . . . Kentland
Larrison, Glenn D. Morocco
MacLeod, Donald F. Morocco
Williams, H. J. Morocco
Schantz, Richard Remington
Beaver, Ernest Rensselaer
Johnson, Cecil E. Rensselaer
Kresler, Leon Rensselaer
O'Neill, Martin Rensselaer

Gwin, Merle D. . . 2111 Regatta Ave.,
Miami Beach, Fla.

JAY COUNTY

Garber, Edwin C. Dunkirk
Hall, Emory H. Dunkirk
Heller, Nelson L. R. . . . Dunkirk
Shroyer, Herbert Dunkirk
Hiestand, Harley J. Pennville
Badders, Ara C. Portland
Cring, George V. Portland
Cripe, William Portland
Engle, John M. Portland
Fitzpatrick, James Portland
Hammond, Stanley M. . . . Portland
Keeling, Forrest E. Portland
Lyon, Florence Portland
Moran, Mark M. Portland
Spahr, Donald E. Portland
Steffy, Ralph Portland
Lansford, John Redkey

JEFFERSON-**SWITZERLAND COUNTY**

Robertson, David W. (S) . . . Deputy
Henning, Carl Hanover

Madison

Alcorn, Merritt O., Jr. . . . 428 E. Main St.
Beetem, Luther F. . . . 425 W. Main
Childs, A. G. W. (S) . . . 412 E. Main
Childs, Wallace E. . . . 420 Elm
Denny, Fred C. . . . Odd Fellows Bldg.
Hare, Francis W., Jr. . . . Madison Clinic

Jolly, Lewis E. . . . Madison Clinic
May, George A. . . . 426 E. Main
McAtee, Otto B. . . . Madison State Hospital

Modisett, Jackson W. . . . Madison Clinic

Modisett, Marcella S. . . . Madison Clinic

Petway, Allen P. . . . 426 E. Main
Prenatt, Francis Madison State Hospital

Shuck, Wm. A. . . . Odd Fellows Bldg.
Turner, Anna L. . . . 104 E. Third
Turner, Oscar A. . . . 104 E. Third
Whitsitt, Schuyler A. (S) . . . 718 W. Main

Zink, Robert O. . . . Madison Clinic

Bear, Lowery, H. (S) Vevay
Ellerbrook, George E. . . . Vevay
Graves, Noel S. Vevay
Cook, Elbert C. (S) R.R. 1, Bradenton, Fla.

Hamilton, Guy (S) 1420 Santa Domingo Ave.,
Durate, Calif.

Nichols, Wm. G. . . . VA Hospital, Philadelphia 4, Pa.
Sharman, Edward J. . . . VA Hospital, Marion, Ill.

JENNINGS COUNTY

Lutes, David L. Butlerville
Daubenhey, Miles F. (S) . . . Butlerville

Peppel, Howard J. . . . Butlerville
Calli, Louis North Vernon
Green, John H. North Vernon

JENNINGS COUNTY

(Continued)

Johnson, William A. North Vernon
 Matthews, Dennis W. North Vernon
 Neucks, Howard C.

R. R. 2, North Vernon
 Stemm, Wm. H. (S) North Vernon
 Thayer, Benet W. North Vernon

JOHNSON COUNTY

Manuel, Donald Edinburg
 Michaels, Joseph F. (S) .. Edinburg
 Chappel, Alfred T. Franklin
 Deppe, Charles F. Franklin
 Eaton, Lyman D. Franklin
 Ferrara, Joseph F. Franklin
 Foster, Robert. Franklin
 Jones, Charles A. Franklin
 Murphy, Harry E. Franklin
 Portteus, Walter L. Franklin
 Province, Oran A. (S) ... Franklin
 Province, William D. Franklin
 Records, Arthur W. Franklin
 Barnes, Helen Beall. ... Greenwood
 Brown, George E. Greenwood
 Dagley, Hubert R. Greenwood
 Sheek, Kenneth I. Greenwood
 Tiley, George A. Greenwood
 Woodcock, Charles E. ... Greenwood
 Machledt, John H. Whiteland

KNOX COUNTY

Byrne, Robert J. Bicknell
 Donham, William L. Bicknell
 Fox, Richard H. (S) Bicknell
 Meade, Walter W. Bicknell
 Wilson, Guy H. Bicknell
 Scudder, John A. Edwardsport
 Hodges, William A. Oaktown
 Springstun, George H. ... Oaktown
 Pahmeier, John W. Sandborn

Vincennes

Anderson, Richard M.
 301 LaPlante Bldg.
 Arbogast, Paul B. 915 Main
 Bailey, W. A. (S) 516 Busseron
 Beckes, E. W. 603 Busseron St.
 Boyd, Claudius L. (S)
 114 N. Fourth
 Chattin, Herbert O. 729 Main
 Coffel, Melvin H.
 424 LaPlante Bldg.
 Cullison, Charles W. R.R. 4
 Curtner, Myron L. 222 N. Sixth
 Davis, Howard B. 621 Seminary St.
 Edwards, Edward T., Jr.
 1045 Washington Ave.
 Ewing, Nathaniel D. 14 N. Third
 Fox, Maurice S. 616 Shelby St.
 Gilmore, Louis L. (S)
 430 N. 2nd St.
 Green, Carl L. 1004 Main
 Hoffman, Doris. 720 Perry St.
 Humphreys, Joe E. 217 N. Third
 Johnson, Morris H. C. R.R. 1
 Keezer, William S. Vincennes
 McCormick, Hubert D.
 325 LaPlante Bldg.
 McDowell, Mordecai M.
 611 Dubois
 McMahan, Virgil C.
 410 LaPlante Bldg.
 Meyer, Raymond C. Hillcrest Hosp.

KNOX COUNTY

(Vincennes—Continued)

Moore, Robert G. 21 N. Third
 Nance, William K. 720 Perry St.
 Reilly, James F. 401 Buntin St.
 Richards, D. H. (S)
 215 American Nat. Bk. Bldg.
 Schulze, William
 223 American Bank Bldg.
 Shaffer, Kenneth L.
 404 LaPlante Bldg.
 Smith, Ralph O. 12 S. Fourth
 Smith, Saml. J. 301 LaPlante Bldg.
 Spencer, Frederic
 421 LaPlante Bldg.
 Sullenger, A. A. 803 Seminary St.
 Welch, Norbert M.
 410 LaPlante Bldg.

KOSCIUSKO COUNTY

Thomas, Charles E. (S) .. Leesburg
 Urschel, Dan Mentone
 Stalter, Gaylord W. N. Webster
 Schuldt, T. S. Pierceton
 Clark, Fred Syracuse
 Craig, Robert A. Syracuse
 Fosbrink, E. L. Syracuse
 DuBois, Charles C. (S) ... Warsaw
 Haymond, George M. Warsaw
 Hillery, John L. Warsaw
 Murphy, Harold O. Warsaw
 Pullman, George R. Warsaw
 Richer, Orville H. Warsaw
 Roesch, Ryland Warsaw
 Schlemmer, George H. Warsaw
 Thomas, Everett W. Warsaw
 Waltz, Frank C.
 Box 1015, Punta Gorda, Fla.

LAGRANGE COUNTY

Wade, Alfred A. Howe
 Yunker, Philip E. Howe
 Benedict, Charles D. LaGrange
 Flannigan, Harley F. LaGrange
 Studebaker, Lloyd R. LaGrange
 Weir, Dale LaGrange
 Williams, John H. Shipshewana
 Hildebrand, William O. (S) Topeka
 Lehman, Kenneth M. Topeka

LAKE COUNTY

Bolin, John T. Cedar Lake
 King, Robert W. Cedar Lake
 King, William B. Cedar Lake
 Misch, William Cedar Lake

Crown Point

Becker, Philip H.
 Lake County T. B. Sanitarium
 Birdzell, John P. 124 N. Main
 Carroll, Mary E. 124 N. Main
 Gray, Daniel E. 235 S. Main
 Horst, William N. 123 N. Court St.
 Klaus, J. M. 224 S. Court
 Merchant, Raymond. 269 Maxwell
 Monroe, F. Bruce. Crown Point
 Seyler, Anna G.
 Lake County T. B. Sanitarium
 Steele, Everett B. 124 N. Main
 Troutwine, William 224 S. Court
 Weis, William D. (S) Court House

Adler, Edmund R. Dyer

LAKE COUNTY

(Continued)

East Chicago

Barron, Elmer A. 3406 Guthrie St.
 Beam, Vernon B. Du Pont Co.
 Beilke, Clifford A. 815 W. Chicago
 Benchick, Frank A.
 4712 Magoun Ave.
 Benedek, Tibor 3406 Guthrie St.
 Bernardi, Hugh. 3406 Guthrie
 Bonaventura, Angelo P.
 3701 Main St.
 Boyd, Chas. S. 4739 Melville Ave.
 Boys, Fay F. 722 W. Chicago Ave.
 Brauer, Abraham A. 3528 Main St.
 Braun, Benjamin D.
 St. Catherine's Hospital
 Broomes, Edw. L. 2301 Broadway
 Callahan, Richard H. 3704 Main St.
 Campagna, Ettro A. 3406 Guthrie
 Carleton, Edward H.
 Inland Steel Co.
 Cole, Arthur V. 3406 Guthrie St.
 Corrao, Gaetano 2220 Broadway
 Cotter, Edward R.
 723 W. Chicago Ave.
 Dainko, Alfred J.
 823 W. Chicago Ave.
 Ernst, H. C. 720 W. Chicago Ave.
 Fleischer, Jacob C. 3406 Guthrie
 Fortier, Edward G. 3210 Watling
 Gardiner, H. Glenn. 3210 Watling
 Goralka, Joseph J.
 3538 Central Ave., E. Gary
 Govorchin, Alexander
 724 W. Chicago Ave.
 Grosso, William G.
 722 W. Chicago Ave.
 Gustaitis, John W.
 815 W. Chicago Ave.
 Hamilton, Robert C.
 2602 E. 140th Place
 Hayes, Jesse D. 4742 Melville
 Irish, Wilbur J.
 806 W. Chicago Ave.
 Johns, David R.
 724 W. Chicago Ave.
 Kamen, Jack M. 3406 Guthrie
 Komoroske, John E.
 723 E. Chicago Ave.
 Levin, Eli 3700 Main St.
 McGuire, Desmond F.
 3429 Michigan Ave.
 Marks, Ora L. 815 W. Chicago Ave.
 Nicosia, John B. 3701 Main St.
 Payne, Arthur C. 2020 Broadway
 Ramker, Daniel T.
 3406 Guthrie Ave.
 Shapiro, Joseph. 3701 Main St.
 Shulruff, H. I. 3701 Main St.
 Silberman, Jack. 3738 Main St.
 Teegarden, Joseph A., Jr.
 1919 E. Columbus Dr.
 Teegarden, Joseph A.
 1919 E. Columbus Dr.
 Trepagnier, Francis B.
 3616 Main St.
 Zallen, Stanley G.
 720 W. Chicago Ave.
 Zivich, John M. 3701 Main St.

Gary

Almquist, Carl O. 504 Broadway
 Armalavage, Leon J. 504 Broadway
 Baitinger, Herbert M.
 504 Broadway
 Behn, Walter M. 738 Broadway

LAKE COUNTY

(Gary—Continued)

Bendler, Carl H. 738 Broadway
 Bills, Robert N. 504 Broadway
 Boardman, Carl 504 Broadway
 Borak, Walter J. 6151 W. 25th Ave.
 Brady, Samuel G. 765 Broadway
 Brandman, Harry 504 Broadway
 Brink, Calvin C. 504 Broadway
 Brown, David B. 504 Broadway
 Brown, Leo R. 3855 Broadway
 Bullard, Mattie J. 524 Garfield St.
 Burcham, James B. 738 Broadway
 Carberry, George A. 738 Broadway
 Carbone, Joseph A. 504 Broadway
 Carmody, Raymond F. 504 Broadway
 Chevigny, Julius J. 504 Broadway
 Cooper, Leo K. 670 Hayes St.
 Crossland, Steward H. 560 Hayes St.
 Danielewski, L. J. 738 Broadway
 Darling, Dorothy 1600 W. 6th Ave.
 Davis, Neal, Box 928, Ogden Dunes
 Dian, August J. 729 Broadway
 Dian, Julia 584 Garfield
 Dierolf, Edward J. 504 Broadway
 Donchess, Joseph C. 215 Broadway
 Doty, James R. 504 Broadway
 Duncan, John S. 2165 W. 11th St.
 Elliott, Ralph A. 504 Broadway
 English, Hubert M. 673 Broadway
 Gannon, G. W. 602 Broadway
 Goldberg, Harold B. 515 Broadway
 Goldstone, Adolph 757 Broadway
 Goldstone, Joseph 757 Broadway
 Goldstone, S. R. 757 Broadway
 Grant, Benjamin 1706 Broadway
 Gregoline, A. F. 729 Broadway
 Hedrick, James T. 1901 Broadway
 Hodurski, Zigfield 4319 Broadway
 Holmes, George W. 504 Broadway
 Jahns, Albin A. 504 Broadway
 Jannasch, Maurice C. 738 Broadway
 Johnson, Lonnie B. 123 W. 21st St.
 Kendrick, Frank J. 504 Broadway
 Khaton, Odessa M. 2107 Carolina St.
 Kobrin, Meyer W. 729 Broadway
 Kolettis, George J. 860 Broadway
 Kopcha, Joseph E. 504 Broadway
 Korn, Jerome M. 742 Broadway
 Kron, R. Vincent 3538 Central, East Gary
 Lebioda, Henry S. 8 W. Ridge Rd.
 Lewis, George N. 504 Broadway
 Lorenty, Thaddeus B. 738 Broadway
 Lovell, Martin H. 1606 Broadway
 Lutz, Georgianna 504 Broadway
 McMichael, F. J. 504 Broadway
 Majsterek, Stanley L. 1902 W. 11th Ave.
 Marcus, Morris C. 738 Broadway
 Marshall, Millard R. 504 Broadway
 Mather, J. W. 3543 Central, East Gary
 May, Richard M. 583 Broadway
 Mercer, Arthur H. 1600 W. 6th Ave.
 Minczewski, Richard C. 504 Broadway
 Molengraft, Cornelius J. 527 Broadway
 Moore, E. Gregory 1901 Broadway
 Moore, Edwin G. 1606 Broadway

LAKE COUNTY

(Gary—Continued)

Morris, Hyman 17 W. 8th Ave.
 Moswin, Jack A. 504 Broadway
 Nelson, Walfred R. 559 S. Lake St.
 Neuwelt, Frank 504 Broadway
 Ornelas, Jos. P. 673 Broadway
 Palmer, Russell H. 2006 W. 4th Place
 Parratt, Louis W. 708 Broadway
 Reynolds, James S. 504 Broadway
 Robinson, Walter K. 504 Broadway
 Rosenbloom, Philip J. 504 Broadway
 Roth, Leo 738 Broadway
 Rubin, Simon S. 504 Broadway
 Ryan, Hubert J. 504 Broadway
 Sagel, Jacob 504 Broadway
 Sala, Joseph J. 504 Broadway
 Sala, Walter R. 504 Broadway
 Schaible, Ernest L. 738 Broadway
 Senese, Thos. J. 504 Broadway
 Shellhouse, Michael 3811 Washington St.
 Shevick, Alexander 504 Broadway
 Skeen, Earl D. 504 Broadway
 Slama, George D. 3624 Buchanan
 Slama, John T. 3520 Polk St.
 Spellman, Frank W. 401 S. Lake
 Spivack, Mary 3855 Broadway
 Sponder, Joseph 1512 Broadway
 Stimson, H. R. 504 Broadway
 Stoycoff, Christo M. 844 Broadway
 Thomas, Daniel D. 738 Broadway
 Thomas, Gerald J. 504 Broadway
 Trinosky, Donald L. 504 Broadway
 Turgi, Robert W. 504 Broadway
 Verplank, Grover L. 527 Broadway
 Vye, James P. 522 Broadway
 Walters, Eleanore 522 Broadway
 Washington, G. Kenneth 1606 Broadway
 Weiskopf, Henry S. 504 Broadway
 Westhaysen, Peter 504 Broadway
 Wharton, Russell O. 703 Johnson St.
 White, W. J. (S) 790 Broadway
 Wicks, Orlando C. (S) 560 Van Buren
 Williams, Alexander S. 504 W. 25th St.
 Wimmer, Robert N. 9 W. 6th St.
 Yarrington, Charles W. (S) 607 Broadway
 Yocum, Paul S. 738 Broadway
 Yocum, Wm. S. 583 Broadway
 Young, George M. 3776 Broadway
 Young, Robert L. 11—7th Ave.

Hammond

Allegretti, Michael L. 5404 Hohman Ave.
 Amberg, Edward A. 137 Rimbach
 Arbeiter, Herbert I. 5231 Hohman Ave.
 Arrowsmith, James L. 5231 Hohman Ave.
 Beconovich, Robt. 839-169th St.
 Black, Charles E. 6618 Kennedy Ave.

LAKE COUNTY

(Hammond—Continued)

Carlo, Joseph F. 5305 Hohman Ave.
 Chidlaw, B. W. 5141 Hohman Ave.
 Clancy, James F. 5231 Hohman Ave.
 Cook, George M. 5231 Hohman Ave.
 Davis, Alice L. 5116 Hohman Ave.
 Eggers, Ernest L. 5141 Hohman Ave.
 Eggers, Henry W. 5231 Hohman Ave.
 Egnatz, Nicholas 522 State St.
 Elledge, Ray 5231 Hohman Ave.
 Fischer, Burnell 7403 Van Buren Ave.
 Friedman, Isadore E. 5246 Hohman Ave.
 Gevirtz, Milton B. 5246 Hohman Ave.
 Groman, Herman C. 137 Rimbach
 Hack, Edmund C. 5219 Hohman Ave.
 Hansen, Arthur H. 445 State St.
 Hickman, A. L. 5248 Hohman Ave.
 Hofmann, Andrew (S) 5135 Hohman Ave.
 Hopkins, J. R. 5231 Hohman Ave.
 Howard, William H. 5231 Hohman Ave.
 Husted, Robert G. 7248 Forest
 Jones, Eli S. 5231 Hohman Ave.
 Kaplan, Benj. B. 2035—169th St.
 Kolanko, Leon A. 5435½ Hohman Ave.
 Koransky, David S. 5231 Hohman Ave.
 Kretsch, R. W. 5231 Hohman
 Kuhn, Hedwig S. 112 Rimbach St.
 Kuhn, Hugh A. 112 Rimbach St.
 Larrabee, James F. 5245 Hohman Ave.
 Lautz, Herbert A. 112 Rimbach St.
 Lazo, Vicente R. 5446 Calumet Ave.
 Lipsey, Alfred J. 5252 Hohman Ave.
 McLean, James S. 5252 Hohman Ave.
 McVey, Clarence A. 5231 Hohman Ave.
 Marcus, Emanuel 5252 Hohman Ave.
 Marks, Salvo 409 Yale Bldg.
 Mason, Richard L. 132 Rimbach St.
 Matthews, Charles B. (S) 5252 Hohman Ave.
 Modjeski, Joseph R. 5451½ Hohman Ave.
 Modjeski, Raymond J. 5231 Hohman Ave.
 Morrison, Lindsey (S) 109 Rimbach St.
 Murphy, Joseph F., Jr. 5252 Hohman Ave.
 Musacchio, Frederick A. 330 City Hall
 Nakadate, K. James 917 173rd Place
 Neal, Leonard W. 5252 Hohman Ave.
 Nodinger, Louis 540 165th St.

LAKE COUNTY

(Hammond—Continued)

Panares, Solomon V.
5434 Hohman Ave.
Paul, William Thomas F.
5434 Hohman Ave.
Peck, Edward A.
6422 Moraine Ave.
Peiffer, Geraldine M.
5305 Hohman Ave.
Pilot, Jean5231 Hohman Ave.
Premuda, F. F. .6727 Kennedy Ave.
Rawlins, Carolyn M.
422 Conkey St.
Remich, Antone C. .137 Rimbach St.
Rendel, Donald T.
5231 Hohman Ave.
Rhind, A. W. . . .5145 Hohman Ave.
Riordan, John F.
5231 Hohman Ave.
Rosenthal, Carl .5252 Hohman Ave.
Rosevear, Henry S.
5231 Hohman Ave.
Row, Perrie Q. .5231 Hohman Ave.
Rudolph, Franklin G.
5231 Hohman Ave.
Schlesinger, Jacob
6010 Columbia Ave.
Schulfer, Richard J.
6719 Calumet Ave.
Seglin, Robbert .5306 Hohman Ave.
Shanklin, E. M. (S)
5946 Hohman Ave.
Skrentny, Stanley
5231 Hohman Ave.
Sroka, Alexander G.
6010 Columbia Ave.
Stasick, Murray . .60 Douglas St.
Stern, Samuel L.
5231 Hohman Ave.
Tilka, Edward . .6719 Calumet St.
Walker, Adolph P. .1135 River Drive
Wisniewski, Edward M.
6618 Kennedy Ave.
Wood, Frederic H.
49 Muenich Court

Acos, James C.
2805 Highway Ave., Highland
Markey, Richard J. P.
2805 Highway Ave., Highland
Sroka, Stanley J.
8606 Kennedy Ave., Highland
Vore, Hugh A. . . .8680 Prairie Ave.
Highland
Bjorklund, C. RayHobart
Dupes, Lowell E.Hobart
Friedrich, Louis M. (S) . . .Hobart
Markle, Joseph G.Hobart
Parker, Harry C.Hobart
Pike, Warren H.Hobart
Reed, JohnHobart
Spears, John M.Hobart
Storer, W. R.Lowell
Mirro, John A.Lowell
Templin, David B.Lowell
Campbell, Guy C.Munster
Teplinsky, Louis L.Munster

Whiting

Best, Robert C.
1902 Indianapolis Blvd.
Ferry, John
1902 Indianapolis Blvd.
Frankowski, Clementine E.
1907 New York Ave.

LAKE COUNTY

(Whiting—Continued)

Greisen, Jack G.
1902 Indianapolis Blvd.
Jones, Clifford M.
1902 Indianapolis Blvd.
Kudele, Louis T. . . .1321 119th St.
LaFollette, Forrest R.
1900 Indianapolis Blvd.
McCarthy, Jeremiah A.
1341 E. 119th St.
Rudser, Donald H.
1902 Indianapolis Blvd.
Silvian, Harry A. . . .1400 119th St.
Smith, Theodore J.
1902 Indianapolis Blvd.
Stecy, Peter
1902 Indianapolis Blvd.
Steen, Lowell H.
1900 Indianapolis Blvd.
Thegze, G. A.1344 119th St.
Troy, Jack M.
1902 Indianapolis Blvd.
Weinberg, B. A. . . .1348 119th St.

Bechtol, Lavon D.
Baxter Labs., Morton Grove, Ill.
Benning, Charles H. P. G.
Health Commissioner,
Wilmington, Del.
Bergan, Joseph A.
VA Hosp., McKinney, Texas
Dassel, Paul M.
44 S. 20th St., Maywood, Ill.
Detrick, Herbert W.
Box 203, Alamo, Texas
Galante, Vincent J.
1215 N. Linden Ave.,
Oak Park, Ill.
Justen, Jerome W.
704 Wentworth,
Calumet City, Ill.
Kahan, Harry L.
1748 E. 2nd St., No. 1,
Tucson, Ariz.
Kobrak, H. G.950 E. 59th St.,
Chicago 31, Ill.
Kopanko, Bernard F. . . .St. Mary's
Hosp., Huntington, W. Va.
Lewis, Marvin
2600 N. Lawrence Ave.,
Philadelphia 33, Pa.
O'Connor, James J. . . .3841 Colles
Ave., Los Angeles 33, Calif.
Richter, Samuel
Charity Hosp., New Orleans, La.
Schlesinger, Daniel J. Presbyterian
Hosp., Pittsburgh, Pa.
Shafer, Sid J.
55 E. Washington St.,
Chicago, Ill.
Stevens, Edwin W. . .586 State Line
St., Calumet City, Ill.
Tyrrell, Thomas C.
704 Wentworth Ave.,
Calumet City, Ill.

LAPORTE COUNTY

Oak, David, Jr.Hanna
Potter, BrianKingsbury
Oak, David D.LaCrosse

LaPorte

Carter, Fred S. . . .920 Indiana Ave.
Elshout, Clem H. .1004 Indiana Ave.
Fargher, Robert A.
811 Jefferson Ave.

LAPORTE COUNTY

(LaPorte—Continued)

Farnsworth, Samuel A.
1012 Michigan Ave.
Feinn, Harry S. .1013 Indiana Ave.
Fischer, Carlton N.
1001 Maple Ave.
Jones, John C.801 Madison
Jones, Robert B.
808 Michigan Avenue
Kelsey, Robert M. . .702 Maple Ave.
Kepler, Robert W. .708 Harrison St.
Kistler, James J. . . .911 Maple Ave.
Kring, Gerald G. .704 Jefferson Ave.
Larson, G. O. . . .1110 Indiana Ave.
Linn, Elbert E. . . .809 Jefferson St.
Martin, William B.
812 Michigan Ave.
Morgan, Samuel P.
810 Michigan Ave.
Muhleman, C. E. . .901 Indiana Ave.
Przednowek, Adolph C.
909 Madison St.
Richter, John C. .808 Michigan Ave.
Ross, Wilbur W. . . .P. O. Box 102
Scott, John S.806 Maple Ave.
Simon, Arthur R. . .806 Maple Ave.
Von Asch, George . .912 Monroe St.
Wilcox, Robert F. . .808 Maple Ave.
Wolf, William E.
1406 Lincoln Way

Michigan City

Armstrong, Thomas D.
120 W. Ninth St.
Baker, Warren . .427 Warren Bldg.
Bankoff, Milton L. . .125 E. 5th St.
Bernoske, Daniel G. . .731 Pine St.
Brooks, Harry L. . .125 E. 5th St.
Burris, Floyd L. . . .731 Spring St.
Carlson, Norman R. . .229 E. 5th St.
Cleveland, John B.
801 W. Washington St.
Fargher, Francis M.
907 Washington St.
Feerer, Donald .117 W. Seventh St.
Flaherty, Walter T.
1016 Washington St.
Frost, Robert J.817 Pine St.
Gardner, Melvin D.
801 Washington St.
Gardner, Russell A.
801 Washington St.
Gilmore, Robert W.
2234 Oriole Trail
Gilmore, Russell A.
301 Warren Bldg.
Grotts, Bruce F.
929½ E. Michigan
Henderson, N. C.
622½ Franklin St.
Hillenbrand, Charles
128 W. Tenth St.
Hoover, Ammon W. .125 E. 5th St.
Jones, King Solomon
328½ Franklin St.
Kemp, John T.122 E. 7th St.
Kerrigan, John F.
916 Washington St.
Kerrigan, Robert L.
916 Washington St.
Kling, Victor F. . .507 Warren Bldg.
Kohrman, Benjamin M.
125 E. Fifth St.
Krieger, George M.
701 Washington St.

LAPORTE COUNTY

(Michigan City—Continued)

Kubik, Francis J. 201 E. 8th St.
 Meyer, Milo G. 801 Washington St.
 Milne, Walter S.

916 Washington St.
 Molenda, Robert V. . . . 902 Pine St.
 Paul Leonard G. 125 E. 5th St.
 Piazza, Leonard F.

907 Washington St.
 Pilecki, Peter J. 125 E. 5th St.
 Plank, C. Robert. 732 E. Pine St.
 Reed, Nelle 501 Pine St.
 Robrock, Lawrence M.

315 Warren Bldg.
 Shortall, James P. Smith Bldg.
 Spinning, A. L. (S)

Kenwood Place
 Stumer, Myer 125 E. 5th St.
 Walters, William H. . . . Warren Bldg.
 Warren, Frank R. (S)

723 Franklin St.
 Weeks, Patrick H. Box 41
 Zalac, Donald A. 723 Pine St.

Weinstock, Adolph. Rolling Prairie
 Moosey, Louis Union Mills
 Hetman, Mitchell J. . . . Westville
 Sisson, Helen M. Westville
 Townsend, Ralph Westville
 Van Den Bosch, Wallace R.

Westville
 Benz, Owen Wanatah
 Cartwright, Jack D.

107 Grecian Dr.,
 San Antonio, Texas

LAWRENCE COUNTY

Bedford

Allen, L. Howard
 305 Citizens Nat. Bank Bldg.
 Austin, Richard P.

209 Citizens Nat. Bank Bldg.
 Benham, L. E.

206 Citizens Bank Bldg.
 Bridwell, Edgar 1317 L St.
 Duncan, Raymond. 1317 L St.
 Dusard, Joseph C.

304 Citizens Nat. Bank Bldg.
 Edmonds, Kendrick . . . 1303 15th St.
 Emery, Charles B. 1027 15th St.
 Fountaine, Thomas J.

200 Citizens Nat. Bank Bldg.
 Hammel, Howard T.

Citizens Nat. Bank Bldg.
 Kerr, Donald M. 1317 L St.
 Meyer, Orlando L. 1317 L St.
 Newland, Arthur E. . . . 1112 15th St.
 Noe, William R. 1307 L St.
 Robertson, Moorman O.

400 Citizens Nat. Bank Bldg.
 Scherschel, John P. . . . 1711 H St.
 Smallwood, Robert B.

204 Citizens Nat. Bank Bldg.
 Wohlfeld, Julius B. . . . 1124 16th St.
 Woolery, Richard

207 Citizens Nat. Bank Bldg.
 Wynne, Roland E.

301 Citizens Nat. Bank Bldg.

Hamilton, James R. Mitchell
 Oswalt, James Telfer. . . Mitchell
 Dollens, Claude Oolitic

MADISON COUNTY

Carpenter, John L. Alexandria
 Gaunt, Everett W. Alexandria
 Keller, Frank G. (S) . . . Alexandria
 McClelland, Harry N. . . . Alexandria
 Overpeck, George H. . . . Alexandria
 Shafer, Richard H. Alexandria

Anderson

Aagesen, Walter J.
 702 Citizens Bank Bldg.

Armington, Charles L.
 657 Anderson Bank Bldg.

Armington, John C. (S)
 657 Anderson Bk. Bldg.

Armington, Robert L.
 318 Citizens Bank Bldg.
 Ashcraft, John R. . . . 1424 E. 8th St.
 Austin, Charles E.

2108 Nichol
 Austin, Maynard A. (S)
 238 W. 12th St.

Ayres, Kenneth D.
 2210 Meridian St.

Baughn, William L.
 Guide Lamp Div.

Benoit, Merrill P. Delco Remy
 Bixler, Donald P. 1410 Brown St.
 Blassaras, Chris. 2005 Broadway

Brauchla, Carl H. 117 W. 17th St.
 Brock, Earl E. 931 Meridian St.
 Brown, James M.

609 Anderson Bldg.
 Buckles, David L. St. John's Hosp.
 Conrad, Ernest M. (S)

2124 Meridian
 Dixon, Rex W. 934 W. 8th St.
 Doenges, James L.

631 Citizens Bank Bldg.
 Donaldson, Frank C.
 712 Anderson Bank Bldg.

Drake, John C.
 604 Anderson Bank Bldg.

Ellis, Seth W.
 717 American Bank Bldg.
 Elsten, Aubrey W.

704 Anderson Bank Bldg.
 Fischer, Warren E.
 St. John's Hospital

Gante, Henry W.
 1110 N. Meridian St.

Hart, William D.
 515 Citizens Bank Bldg.

Hensler, Benton M.
 1709 Nichol Ave.

Irwin, Seth. 2209 Cedar St.
 Jones, Albert T.
 530 Anderson Bank Bldg.

Jones, Horace E.
 1110 Meridian St.

Kelly, Wendell C. 704 E. 8th St.
 King, Joseph W.
 1110 N. Meridian St.

Kopp, Otis A. 1110 N. Meridian St.
 Lahr, Philip A.
 412 Anderson Bank Bldg.

Lamey, James L.
 447 Citizens Bank Bldg.

Lamey, Paul T.
 423 Citizens Bank Bldg.

Larmore, Joseph L.
 612 Anderson Bank Bldg.
 Larmore, Sarah M. R. R. 8
 Litzenberger, Sam W.
 622 Citizens Bank Bldg.

Long, Paul L.
 710 Anderson Bank Bldg.

MADISON COUNTY

(Anderson—Continued)

McDonald, Vergil G.
 1110 Meridian St.

Maxson, R. V. 3240 Maryland Dr.
 Meister, Doris (S)
 403 Citizens Bank Bldg.

Metcalf, George B.
 931 Meridian St.

Miley, Weir M. 717 Madison St.
 Morris, Robert A.
 320 Citizen Bank Bldg.

Neale, Alfred
 234 Citizens Bank Bldg.

Nelson, Paul L. 330 West 7th St.
 Nesbit, Leonard L.
 415 Citizens Bank Bldg.

Patterson, William K.
 St. John's Hospital

Polhemus, Warren C.
 1803 Pearl St.

Quickel, Daniel S. (S)
 5 Griffith Bldg.

Reed, Roger R.
 412 Anderson Bank Bldg.

Rosenbaum, Lloyd E.
 647 Citizens Bank Bldg.

Ross, Guy E.
 661 Citizens Bank Bldg.

Rozelle, Clarence V.
 615 Citizens Bank Bldg.

Sharp, William L.
 449 Citizens Bank Bldg.

Stamper, Joseph H.
 619 State Rd. 67 W.

Swan, Richard C. Delco Remy
 Tracy, Julius R. 738 W. 8th St.
 Webb, Harry. 105 W. 11th St.

Wilder, Gordon B.
 338 W. 8th St.

Wilkinson, Roger L. . . . 4 E. 38th St.
 Williams, Francis 1132 Central

Williams, Robert H.
 1132 Central Ave.

Willson, Canby L.
 315 Anderson Bank Bldg.

Wright, Cecil S.
 523 Citizens Bank Bldg.

Zierer, R. O. St. John's Hosp.

Elwood

Drake, M. C. 1201 Main St.
 Fitzpatrick, Harry W.
 1309 S. Anderson St.

Hanson, Martin F.
 1102 S. Anderson St.

Hoppenrath, Wesley M.
 1300 Main St.

Hoppenrath, William H. (S)
 1300 Main St.

Laudeman, Walter A.
 1515 North A St.

Newcomer, Frank V.
 608 S. Anderson St.

Ploughe, Ralph R. 517 S. Anderson

Scea, Wallace. 1300 Main St.

Bishop, Harry A. Frankton

Ridgway, Alton H. Lapel

Rinne, John L. Lapel

Williams, Robert D. . . . Markleville

Dickey, William M. Pendleton

McLaughlin, Calvin P. . . . Pendleton

VanNess, William C. . . . Summitville

Guthrie, Francis C.
 Vero Beach, Florida

MADISON COUNTY

(Continued)

Jarrett, P. E.
8574 Elm St., Fairchild, Wash.
York, Arthur F.
569 S. Cleveland Ave., No. 11,
St. Paul 5, Minn.

MARION COUNTY

Berger, Morley
902 Main St., Beech Grove
Kim, Young D.
136 N. 17th St., Beech Grove
Ramage, Walter F.
244 S. First St., Beech Grove
Rhea, James C.
801 Main St., Beech Grove
Hade, F. L. Bridgeport
Zerfas, Leon G. . . . R. R. 1. Camby
Garrison, James L. . . . Cumberland
Miller, Joseph A. Cumberland

Indianapolis

A

Abreu, Benedict E.
1200 Madison (6)
Adkins, Harold C. . . 409 E. 30th (5)
Adkins, Onan C.
3635 Watson Rd. (5)
Albertson, Frank P.
3544 W. 16th St. (22)
Aldrich, Harry D.
501 Hume Mansur Bldg. (4)
Aldrich, Howard
4316 E. Washington (1)
Alexander, Ezra D.
617 Indiana, No. 304 (2)
Allen, Robert K.
3202 N. Meridian St. (8)
Alvis, Edmond O.
320 Hume Mansur Bldg. (4)
John T. Anderson
General Hospital (7)
Anderson, Wendell C.
1330 W. Michigan (7)
Appel, Richard H.
603 Hume Mansur Bldg. (4)
Arbogast, J. L.
I.U. Med. Center (7)
Arbuckle, Russell L.
244 N. Meridian St. (4)
Arbuckle, Wm. E. . . . 1156 Lee (21)
Arnold, Aaron L.
607 E. Maple Rd. (5)
Arnold, Robert D. 3419 E. 10th (1)
Aronson, Sidney S.
618 Hume Mansur Bldg. (4)
Avery, George
707 S. Shepard (21)

B

Bachmann, Arnold J.
3440 N. Meridian (8)
Bailey, Orville T.
1315 W. 10th St. (2)
Bakemeier, Otto H.
5503 E. Washington (19)
Balch, James F.
709 Hume Mansur Bldg. (4)
Ball, John R. . . 1418 W. 10th St. (2)
Ball, Joseph E. . . 4312 E. 10th (1)
Banister, Revel F. 2958 Central (5)

Banks, Horace M.
Methodist Hosp. (7)
Barry, M. Joseph, Sr.
508-509 Doctors' Bldg. (4)
Bartley, Max D.
803 Hume Mansur Bldg. (4)
Batman, Gordon W.
723 Hume Mansur Bldg. (4)
Battersby, J. Stanley
I. U. Medical Center (7)
Batties, Paul A.
308 Walker Bldg. (2)
Bauer, Thomas B.
408 Hume Mansur Bldg. (4)
Baum, Harry
VA Regional Office (9)
Baumeister, Herbert E.
3375 Forest Manor (18)
Beach, Robert R. . . 2630 E. 10th (1)
Bean, Joseph S. 1425 Berwick (22)
Beasley, Thomas J.
112 Berkley Rd. (8)
Beaver, Howard W.
11 E. Raymond (25)
Beck, Evert M.
633 E. Maple Rd. (5)
Becker, Harry G.
6060 College Ave. (20)
Beckman, Henry F. (S)
5245 Washington Blvd. (20)
Beeler, John W.
712 Hume Mansur Bldg. (4)
Beeler, Raymond C.
712 Hume Mansur Bldg. (4)
Behnke, Roy H.
3139 Bonham Dr.
Bergwall, Warren L.
2602 W. Washington St. (22)
Berman, Edward J.
807 Hume Mansur Bldg. (4)
Berman, Jacob K.
807 Hume Mansur Bldg. (4)
Beverland, Malon E.
3036 E. Washington (1)
Bibler, Lester D.
811 Underwriters Bldg. (4)
Bird, Charles R. (S)
301 Hume Mansur Bldg. (4)
Bivin, James H.
30 W. Fall Crk. Blvd. N. Dr. (8)
Blackford, Milforde
1313 W. 10th St. (2)
Blatt, A. Ebner
3209 N. Meridian (8)
Bloemker, Edward F.
2729 Shelby (3)
Boaz, John J. (S)
302 K. of P. Bldg. (4)
Bobb, Kenneth E. 1736 Hall Pl. (2)
Boggs, Eugene F.
2901 N. Meridian St. (8)
Bohner, Caryle B.
822 Hume Mansur Bldg. (4)
Boling, Grover C., Jr.
3308 N. Manor Court (18)
Bond, George S.
1221 N. Delaware St. (2)
Bond, Virginia
2012 Sharon Ave. (22)
Bond, William H.
I. U. Medical Center (7)
Bonsett, Charles A.
Methodist Hosp. (7)
Booher, Norman R.
447 E. Maple Rd. (5)
Booher, Olga Bonke
447 E. Maple Rd. (5)

Booth, Boynton H.
910 Hume Mansur Bldg. (4)
Bowers, Don D.
711 Underwriters Bldg. (4)
Bowman, George W.
5634 Carrollton Ave. (20)
Boyer, Edward B.
725 Hume Mansur Bldg. (4)
Boyer, Floyd A. . . 442 N. Drexel (1)
Brady, Thomas A.
818 Hume Mansur Bldg. (4)
Brayton, John R.
704 Underwriters Bldg. (4)
Brayton, Lee. . . 3342 N. Illinois (8)
Bridges, William L.
I.U. Medical Center (7)
Briggs, Robert W.
406 N. Senate
Brincko, John Methodist Hosp. (7)
Brodie, Donald W.
817 C. of C. Bldg. (4)
Brown, Archie E.
1220 S. Belmont (21)
Brown, David E.
520 Hume Mansur Bldg. (4)
Brown, DeWitt W.
920 Hume Mansur Bldg. (4)
Brown, Edward A. (S)
201 Fountain Sq. Th. Bldg. (3)
Brown, Frances T.
2126 N. Talbot (2)
Brown, Wendell E.
802 C. of C. Bldg. (4)
Browning, James S.
3209 N. Meridian (8)
Browning, William M.
3740 Central (5)
Bruetsch, Walter L.
Central State Hospital (22)
Buck, Charles E.
3506 Lesley Ave. (18)
Bunde, Carl A.
Pitman-Moore Co. (6)
Burdette, Harold F.
3202 N. Meridian (8)
Burghard, Rolla D.
3760 N. Sherman Dr. (18)
Burney, Leroy E.
1330 W. Michigan (7)
Butler, John O.
1105 E. Hanna Ave. (27)
Buttz, Rose J. P. . . 112 E. 13th (2)

C

Cahn, Hugo M. . . . 418 E. 30th (5)
Caldwell, Marilyn Riley Hosp. (7)
Call, Herbert F.
321 Hume Mansur Bldg. (4)
Campbell, John A.
I. U. School of Medicine (7)
Canaday, James W. (S)
1229 Prospect (3)
Canganelli, Vincent G.
St. Vincent's Hosp. (7)
Caplin, Irvin. . . 2033 N. Harding (2)
Caplin, Samuel S. . . 111 E. 30th (5)
Carson, Wayne
1011 Hume Mansur Bldg. (4)
Carter, James C.
44 E. 57th St. (20)
Carter, Oren E. . . . 668 E. 38th (5)
Chattin, Wm. R. General Hosp. (7)
Chen, Ko Kuei. . . Eli Lilly & Co. (6)
Christian, William A.
1481 W. 10th St. (2)

MARION COUNTY

(Indianapolis—Continued)

Chroniak, Walter
3941 N. Delaware (5)
Clark, Cecil P.
922 Hume Mansur Bldg. (4)
Clark, Lawson J.
3736 N. Delaware (5)
Clevinger, William G.
1610 Auburn St. (24)
Close, W. Donald
809 Hume Mansur Bldg. (4)
Coble, Ralph R.
3311 N. Meridian (8)
Cohn, Alvin C. Methodist Hosp. (7)
Collins, Hubert L.
985 N. Arlington (19)
Collins, James N.
712 Hume Mansur Bldg. (4)
Conley, Joseph L.
2443 E. Washington (1)
Conway, Chester C.
4402 E. New York (1)
Conway, Glenn . . . 1620 S. East (25)
Cook, Charles J. (S)
1206 Comar Ave. (3)
Copeland, Samuel J. (S)
427 Bankers Trust Bldg. (4)
Cornacchione, Matthew
814 S. East (25)
Cortese, James V. 435 S. East (25)
Cortese, Thomas A.
435 S. East (25)
Countryman, Frank W.
3233 N. Meridian (8)
Courtney, John W.
424 Hume Mansur Bldg. (4)
Cox, Clifford E.
R. R. 16, Box 811 (20)
Craft, Kenneth L.
1002 Hume Mansur Bldg. (4)
Craven, Howard T.
922 Hume Mansur Bldg.
Crawford, John A.
301 Hume Mansur Bldg. (4)
Culbertson, Clyde G.
Lilly Research Lab. (6)
Cullen, Paul K.
422 Hume Mansur Bldg. (4)
Culloden, William G.
710 E. 46th (5)
Cuthbert, Marvin
607 Hume Mansur Bldg. (4)
Czenkusch, Helen G.
1914 MacArthur Lane (24)
D
Dalton, John E.
707-708 Hume Mansur Bldg. (4)
Dalton, William W.
4205 Otterbein (27)
Daniel, John C.
1008 Hume Mansur Bldg. (4)
Davidson, Dale A.
I. U. Medical Center (7)
Davidson, N. Cort
3008 Clifton (23)
Davis, John A. . . . 2719 E. Mich. (1)
Davis, Sam J.
908 Hume Mansur Bldg. (4)
Deal, Eleanor H. B.
1544 Main St., Speedway (24)
Dearmin, Robert M.
3233 N. Meridian (8)
DeArmond, Murray
723 Hume Mansur Bldg. (4)

Deever, John W. . . . 4131 Shelby (3)
DeMotte, C. Bowen
808 C. of C. Bldg. (4)
Denny, Forrest L.
3351 W. 10th (22)
Denny, James W.
5504 E. Washington (19)
Des Jean, Paul A.
638 K. of P. Bldg. (4)
DeWees, Dwight L.
302 N. Bradley (1)
Dill, Myron K.
St. Vincent's Hosp. (7)
Dilts, Robert Louis
2521 E. 38th (18)
Dintaman, Paul G.
432 Bankers Trust Bldg. (4)
Donato, Albert M. 1429 Shelby (3)
Doran, J. Hal
720 Hume Mansur Bldg. (4)
Dorman, Willis L.
5508 E. Washington (19)
Dowd, Joseph A.
6177 College (20)
Drake, William L.
General Hosp. (7)
Duckworth, Alda G.
Methodist Hosp. (7)
Dugan, Thomas J. (S)
2540 W. Washington (22)
Dugan, William M.
410 Hume Mansur Bldg. (4)
Dunbar, Colin V.
423-4 Hume Mansur Bldg. (4)
Dunning, Lehman M.
1561 College (2)
Dyar, Edwin W.
3202 N. Meridian (8)
Dyke, Richard W.
General Hospital (7)

E

Earp, Evanson B.
717 Hume Mansur Bldg. (7)
Eastman, Joseph R., Jr.
817 Merchants Bank Bldg. (4)
Eaton, Edwin R.
1221 N. Delaware St. (2)
Ebert, J. Wayne . . . 509 Lincoln (3)
Eberwein, John H.
5346 Washington Blvd. (20)
Egbert, Herbert L.
504 Hume Mansur Bldg. (4)
Eicher, Palmer O.
3209 N. Meridian (8)
Eikenberry, Hugh W.
616 Bankers Trust Bldg. (4)
Eisenbarth, Elmer J.
846 Lincoln St. (3)
Eldridge, Gail E. . . 1440 E. 46th (5)
Ellis, Bert E.
303 Hume Mansur Bldg. (4)
Emhardt, John T. 1621 S. East (25)
Emhardt, John W. A.
709 Underwriters Bldg. (4)
Ensminger, L. A. (S)
908 Hume Mansur Bldg. (4)
Enzor, Ora K. . . . 4216 College (5)
Ernst, Clifford E.
428 Bankers Trust Bldg. (4)
Evans, Frederick H.
4065 Byram (8)
Evans, Paul V. . . . General Hosp. (7)
Everly, Ralph V. . . 4216 College (5)

F

Failey, Robert B., Jr.
420 Hume Mansur Bldg. (4)
Farrell, Joseph T.
2807 E. Michigan (1)
Fausset, C. Basil
2901 N. Meridian St. (8)
Fisch, Charles
3120 N. Meridian St. (8)
Fischer, Albert A.
St. Vincent's Hosp. (7)
Fitzgerald, William J.
203 Ftn. Sq. Bldg. (3)
Flanigan, Meredith B.
2920 W. 33rd (22)
Flick, John J. . . . 1443 N. Penn. (2)
Flora, Joseph O.
4317 W. Washington (21)
Folkening, Norval C.
204 Ftn. Sq. Bldg. (3)
Foreman, Harry L. . 60 W. 30th (8)
Forry, Frank
I. U. Medical Center (7)
Fosgate, Orville E.
St. Vincent's Hosp. (7)
Foster, Lee N.
St. Vincent's Hosp. (7)
Fouts, Paul J.
522 Hume Mansur Bldg. (4)
Franklin, William L.
508 Hume Mansur Bldg. (4)
Frazin, Bernard
1481 W. 10th St. (2)
Freeborn, Warren S.
St. Vincent's Hosp. (7)
Freeman, Max E.
St. Vincent's Hosp. (7)
Fromhold, Willis A.
611 Bankers Trust Bldg. (4)
Fry, Robert D.
612 Hume Mansur Bldg. (4)
Fullerton, Robert L. 3665 N. Ill. (8)
Funkhouser, Arthur G.
702 Underwriters Bldg. (4)
Funkhouser, Elmer
702 Underwriters Bldg. (4)
Furgason, Paul C.
1008 Hume Mansur Bldg. (4)

G

Gabe, William E.
612 Hume Mansur Bldg. (4)
Gallup, Palmer R.
601 Inland Bldg. (4)
Gambill, William D.
1019 Hume Mansur Bldg. (4)
Gammieri, Robert L.
3326 Clifton (23)
Garber, J. Neill
806 Hume Mansur Bldg. (4)
Garceau, George J.
508 Hume Mansur Bldg. (4)
Gardiner, Sprague H.
314 Hume Mansur Bldg. (4)
Gardner, Buckman
St. Vincent's Hospital (7)
Garfield, Martin D.
3705 College (5)
Garner, William (S)
2911 E. 10th (1)
Garner, W. Stanley
2911 E. 10th (1)
Garrett, John D. (S)
510 Doctors Bldg. (4)
Garrett, Robert A.
I. U. Medical Center (7)

MARION COUNTY

(Indianapolis—Continued)

- Gastineau, David C.
I.U. Medical Center (7)
- Gastineau, Frank M.
407 Hume Mansur Bldg. (4)
- Gatch, W. D.
605 Hume Mansur Bldg. (4)
- Geider, Roy A. . . . 1443 Prospect (3)
- Genovese, Pasquale
1481 W. 10th St. (2)
- George, Charles L. 507 E. 34th (5)
- Gibson, Maxine
5744 Broadway Terrace (20)
- Gick, Herman H.
2705 E. Michigan (1)
- Gifford, Fred E.
710 Hume Mansur Bldg. (4)
- Gillespie, Charles F.
3209 N. Meridian (8)
- Gillespie, Jacob E.
523 Hume Mansur Bldg. (4)
- Gillette, Edward P.
St. Vincent's Hospital (7)
- Glass, Robert L.
608 Hume Mansur Bldg. (4)
- Glendening, John L.
132 Insurance Bldg. (4)
- Goldman, Samuel 1266 Oliver (21)
- Goodwin, Caroline J.
1220 Pickwick Pl. (8)
- Gootee, Francis H.
2130 Catherwood (18)
- Gosman, James H.
2901 N. Meridian (8)
- Graves, John W.
949 Ellenberger Pky. E. Dr. (19)
- Green, Harrison
1011 Hume Mansur Bldg. (4)
- Green, Oscar
6203 Indianola Ave. (20)
- Greenbank, Richard K.
1800 E. Tenth St. (1)
- Greene, Morgan E.
4552 Brookville Rd.
- Greist, John H.
2901 N. Meridian St. (8)
- Griffith, Harold R.
I. U. Medical Center (7)
- Griffith, Richard S. Lilly Clinic (7)
- Griffith, Ross E. . . . 401 E. 34th (5)
- Grisell, Ted L.
504 Hume Mansur Bldg. (4)
- Gustafson, Gerald W.
314 Hume Mansur Bldg (4)
- Gutelius, Charles B. (S)
3028 Park Ave. (5)
- H
- Habich, Carl
702 Hume Mansur Bldg. (4)
- Hadley, David
809 Hume Mansur Bldg. (4)
- Hadley, Murray N. (S)
809 Hume Mansur Bldg. (4)
- Haggard, Edmund B.
806 Board of Trade Bldg. (4)
- Hahn, E. Vernon
914 Hume Mansur Bldg. (4)
- Hall, Jack R. . . . 3342 N. Illinois (8)
- Hamer, Homer G.
1711 N. Capitol (7)
- Hampshire, Donald R.
1443 N. Pennsylvania (2)
- Hancock, John G.
2226 W. Michigan (22)
- Hanley, Edward J., Jr.
615 Hume Mansur Bldg. (4)
- Hann, Eldon C. . . . Methodist Hosp. (7)
- Hanna, Duke, Jr.
2901 N. Meridian (8)
- Hanna, Thomas A.
1608 N. Lynhurst Dr. (24)
- Hansell, R. M. 7 N. Euclid (1)
- Harcourt, Allan K.
812 C. of C. Bldg (4)
- Harding, M. Richard
308 Hume Mansur Bldg. (4)
- Harding, Myron S.
308 Hume Mansur Bldg. (4)
- Hare, Earl H.
1481 W. 10th St. (2)
- Hare, Laura
404 Hume Mansur Bldg. (4)
- Harger, Robert
804 Hume Mansur Bldg. (4)
- Harold, Albert H. (S)
7510 Allisonville Rd. (44)
- Harold, Norris E. (S)
3545 N. Denny St. (18)
- Harris, Carl B.
319 Hume Mansur Bldg. (4)
- Harris, Paul N.
Eli Lilly & Co. (6)
- Hasewinkel, Carroll W.
Methodist Hospital (7)
- Haslinger, Clarence J.
2151 E. New York (1)
- Hatfield, B. F.
802 C. of C. Bldg. (4)
- Hatfield, Jack J.
802 C. of C. Bldg. (4)
- Hatfield, N. W. 2032 N. Rural (18)
- Hatfield, Margaret
1315 W. 10th St. (2)
- Hawk, James H.
514 Hume Mansur Bldg. (4)
- Haymond, Joseph L.
3769 College (5)
- Hays, Everett L. Billings VA Hosp.,
Ft. Benj. Harrison (16)
- Hedrick, Philip W 654 E. 54th (20)
- Heinrichs, Harry H.
434 Bankers Trust Bldg. (4)
- Henderson, F. G. Eli Lilly & Co. (6)
- Hendricks, J. D. (S)
2230 N. Del. (5)
- Hendricks, John W.
911 Hume Mansur Bldg. (4)
- Hennessee, Philip C.
320 Hume Mansur Bldg. (4)
- Henry, Russell S.
725 Hume Mansur Bldg. (4)
- Hepburn, C. K.
524 Hume Mansur Bldg (4)
- Hetherington, A. M.
4121 E. New York (1)
- Hetherington, John A.
822 Hume Mansur Bldg. (4)
- Heubi, J. E. . . . 668 E. Maple Rd. (5)
- Hickman, W. F. . . . 1210 Oliver (21)
- Hildebrand, John O., Jr.
1527 W. 29th St. (23)
- Hilldrup, Don G.
5672 N. Illinois St. (8)
- Hillsamer, Phyllis G.
5665 E. 20th St.
- Himebaugh, James R. S.
2502 English Ave. (1)
- Himler, James M.
809 Underwriters Bldg. (4)
- Hine, U. B. 4808 E. Mich. (1)
- Hines, Don C. . . . Eli Lilly & Co. (6)
- Hodges, Fletcher (S)
VA Regional Office (4)
- Hoffman, Herman
436 Bankers Trust Bldg. (4)
- Hofmann, J. William
323 Hume Mansur Bldg. (4)
- Hollingsworth, A. A.
4032 E. Wash. (1)
- Holman, J. E., Jr. 3315 E. 10th (1)
- Holman, Jerome E., Sr.
3315 E. Tenth St. (1)
- Holsinger, Robert
General Hospital (7)
- Holt, Everett L.
St. Vincent's Hosp. (7)
- Hood, A. A. . . 3205 Shelby St. (27)
- Horwitz, Thomas
423-4 Hume Mansur Bldg. (4)
- Howell, Joseph D.
760 Bankers Tr. Bldg. (4)
- Howell, Robert D.
900 Underwriters Bldg. (4)
- Hoyt, L. H. . . . Methodist Hosp. (7)
- Huber, Carl P.
I.U. Med. Center (7)
- Huddle, John R.
Methodist Hosp. (7)
- Hudson, F. J. 3440 N. Meridian (8)
- Hughes, William F. (S)
4025 N. Meridian St. (8)
- Hull, James E.
General Hospital (7)
- Hull, Ronald H.
1315 W. 10th St. (2)
- Hummons, Francis D.
729½ N. West St. (2)
- Hummons, H. L. . . 729½ N. West (2)
- Hungerford, Louis N.
I. U. Medical Center (7)
- Hurt, Laverne B.
635 E. Kessler Blvd. (20)
- Huse, William M.
703 Hume Mansur Bldg. (4)
- Hynes, Roy T. . . 633 E. 38th St. (5)
- I
- Irwin, Glenn W., Jr.
I.U. Med. Center (7)
- Iske, Paul G.
1015 Hume Mansur Bldg. (4)
- J
- Jackson, Frederick E.
510 Doctors Bldg. (4)
- Jackson, James W.
1330 W. Mich. (7)
- Jackson, J. L. . . . 3001 E. 10th (1)
- Jaeger, A. S. (S)
430 Bankers Tr. Bldg. (4)
- Jaquith, Orville S. (S)
261 Blue Ridge Rd. (8)
- Jay, A. N. . . . 3233 N. Meridian (8)
- Jeffries, K. I. . . . 807 Virginia (3)
- Jenkins, R. E 3311 N. Meridian (8)
- Jennings, Frank L.
Sunnyside Sanatorium (44)
- Jewett, J. H. 3120 N. Meridian (8)
- Jinks, C. H. 4216 College (5)

MARION COUNTY

(Indianapolis—Continued)

Jobes, James E.
305 Traction Term. Bldg. (4)
Jobes, Norman E. (S)
305 Traction Term. Bldg. (4)
Johnson, Thomas W.
529 Bankers Tr. Bldg. (4)
Johnson, W. F. 2121 N. Harding (2)
Jones, Allen W.
6058 College Ave. (20)
Jones, David E.
828 C. of C. Bldg. (4)
Jones, F. P. 4212 E. Michigan (1)
Jones, Roland W.
707 Hume Mansur Bldg. (4)
Joseph, R. M. 1615 S. East (25)

K

Kahle, Dan B. General Hosp. (7)
Kahler, M. V. 2338 W. Mich. (22)
Kahn, A. J. 3120 N. Meridian (8)
Kahn, H. L. 3120 N. Meridian (8)
Kalb, E. L. 356 S. Emerson (19)
Kammen, Leo 3414 Clifton (23)
Kammen, Robt. 3202 W. 16th (22)
Katterjohn, James C.
313 Hume Mansur Bldg. (4)
Kauffman, Nelson N.
2901 N. Meridian St. (8)
Kauffman, Sidney A.
633 E. 38th St. (5)

Keenan, R. L.
615 Hume Mansur Bldg. (4)
Keever, C. H. 5214 College (20)
Keiser, Venice D.
5709 Broadway (20)
Kelley, Clement E.
5029 E. New York St. (1)
Kelly, Don E.
702 Underwriters Bldg. (4)
Kelly, John F.
517 Hume Mansur Bldg. (4)
Kelly, Walter F. (S)
6016 E. Washington (19)
Kelly, W. M. 5438 E. Wash. (19)
Kempf, G. F. General Hospital (7)
Kendrick, W. M. 1829 E. 46th (5)
Kennedy, Hall 2152 N. Meridian (2)
Kennedy, H. F. 1105 Prospect (3)
Kenoyer, Wilbur L.
2139 College Ave. (2)
Kenyon, Omar A.
General Hosp. (7)
Kerr, H. R. 2817 E. Wash. (1)
Ketcham, Jane M.
514 Hume Mansur Bldg. (4)
Kilgore, B. W. 3133 E. 38th (18)
Kime, Edwin N.
711 Underwriters Bldg. (4)
King, William E.
811 Hume Mansur Bldg. (4)
King, W. F. (S) 1330 W. Mich. (7)
Kingsbury, John K.
5462 E. Washington (19)
Kinzel, Robert J. W.
3120 N. Meridian (8)
Kirkhoff, Paul J.
1517 N. Emerson (19)
Kirklin, Oren L.
202 Hume Mansur Bldg. (4)
Kirtley, William R.
Lilly Research Lab. (6)

Kiser, Edgar F.
226 Hume Mansur Bldg. (4)
Kitterman, Harry E.
510 Hume-Mansur Bldg. (4)
Klain, B. V. 4157 College (5)
Knowles, C. Y.
Riley Hospital (7)
Knowles, Robert P.
I. U. Medical Center (7)
Kohlstaedt, George W.
422 Hume Mansur Bldg. (4)
Kohlstaedt, Karl C.
1 E. 36th St. (8)
Kohlstaedt, Kenneth G.
General Hosp. (7)
Koons, Karl M.
922 Hume Mansur Bldg. (4)
Kopecky, R. R.
4131 Shelby St. (27)
Kornafel, L. H.
608 K. of P. Bldg. (4)
Kraft, Bennett
760 Bankers Tr. Bldg. (4)
Kriel, William B.
5630 W. Washington St. (21)
Krueger, Robert B.
General Hosp. (7)
Kuntz, Herman W.
501 Hume Mansur Bldg. (4)
Kurtz, Fred B.
5520 N. Illinois St. (8)
Kurtz, P. L. 668 E. 38th (5)
Kwitny, I. J. 3209 N. Meridian (8)

L

LaDine, C. B. 2440 Station (18)
Lamb, Emmett B.
205 Hume Mansur Bldg. (4)
Lamb, Russell W.
205 Hume Mansur Bldg. (4)
Lamber, Chet K.
912 Hume Mansur Bldg. (4)
Langdon, Harry K. (S)
3264 N. Penn. (5)
Laramore, Ward
5835 N. Keystone (20)
Larkin, Bernard J.
305 Hume Mansur Bldg. (4)
Lawler, G. F. 3934 E. 10th (1)
Lawrence, Edwin A.
I.U. Med. Center (7)
Leasure, J. Kent
611 Hume Mansur Bldg. (4)
Leatherman, Harter L.
1531 Broadway (2)
Leedy, Gladys J.
Central State Hospital (22)
Leff, Abe H. 712 E. 52nd (5)
Leffel, James M., Jr.
3209 N. Meridian (8)
Leffler, William T.
2141 E. 52nd St. (5)
LeMaster, Theodore R.
805 Hume Mansur Bldg. (4)
Leonard, Henry S. (S)
303 Hume-Mansur Bldg. (4)
Leser, Ralph U.
3233 N. Meridian (8)
Levi, Leon 40 W. 38th (8)
Levin, R. T. 3209 N. Meridian (8)
Libbert, Edwin L.
VA Regional Office (4)

Libbert, Edwin L., Jr.
Methodist Hosp. (7)
Lichtenberg, Melvin
535 E. 38th (5)
Lidikay, Edward C.
621 Hume Mansur Bldg. (4)
Lindenborg, Paul G.
1402 N. Olney (1)
Lingeman, Raleigh E.
411 Hume Mansur Bldg. (4)
Lingeman, Roger E.
4143 Blvd. Place (8)
Link, Goethe
608 Ind. Pythian Bldg. (4)
Linton, Charles D.
6130 Carvel, No. 4 (20)
Little, J. W. (S) 2735 E. 10th (1)
Little, William J.
712 Hume Mansur Bldg. (4)
Lochry, Ralph L.
St. Vincent's Hosp. (7)
Long, William H. R. R. 18, Box 534
Loomis, Norman S.
5230 Kenwood (8)
Lord, G. C. 104 E. Maple Rd. (5)
Love, G. N.
1644 N. Delaware St. (2)
Ludwig, O. D. 5433 Madison (3)
Lurie, Paul R.
I. U. Medical Center (7)
Luros, J. Theodore
2901 N. Meridian (8)
Lybrook, William B.
3749 N. Keystone (18)

M

McBride, James S.
810 Hume Mansur Bldg. (4)
McCallum, J. T. C. 237 W. 46th (8)
McCarthy, Daniel J. (S)
3055 N. Meridian (8)
McCartney, D. H.
918 Hume Mansur Bldg. (4)
McCaskey, Carl H.
608 Guaranty Bldg. (4)
McClain, Edwin S.
414 Hume Mansur Bldg. (4)
McCormick, C. O., Jr.
621 Hume Mansur Bldg. (4)
McCormick, C. O., Sr.
621 Hume Mansur Bldg. (4)
McCown, Percy E.
521 Hume Mansur Bldg. (4)
McDevitt, Daniel R.
3202 N. Meridian (8)
McGrath, M. F. 1929 E. 38th (18)
McGue, Frank J.
2444 N. Meridian (8)
McGuff, P. E. 605 E. Maple Rd. (5)
McIntire, Clarence R.
3202 Meridian (8)
McIntyre, Charles J. (S)
414 Hume Mansur Bldg. (4)
McIntyre, J. M.
2901 N. Meridian St. (8)
McKinley, A. David
I.U. Hospitals (7)
McKinstry, Homer R.
707 Underwriters Bldg. (4)
McMillan, Frederick G.
1110 Odd Fellows Bldg. (4)
McNamara, J. P. 5610 College (20)
McQuiston, Ralph J.
608 Guaranty Bldg. (4)
McTurnan, Robert W.
5646 N. Illinois (8)

MARION COUNTY

(Indianapolis—Continued)

- Mackey, H. S. . . . 4309 Central (5)
 Mackey, J. E. . . General Hosp. (7)
 Madtson, A. R. . . . 822 Hume Mansur Bldg. (4)
 Magennis, H. L. 468½ W. Wash. (4)
 Manalan, M. M. . . . 1481 W. 10th St. (2)
 Manion, Marlow W. . . 601 Hume Mansur Bldg. (4)
 Mann, Mortimer . . . 323 Hume Mansur Bldg. (4)
 Manning, K. Randolph . 723 Hume Mansur Bldg. (4)
 Manzie, Michael . . . 807 Hume Mansur Bldg. (4)
 Marks, Maurice I. . . . 2901 N. Meridian St. (8)
 Marshall, A. L., Jr. . . . 1330 W. Michigan St. (7)
 Marshall, C. R. . . . 43 W. 30th (8)
 Martin, H. E. . . . 1200 Madison (6)
 Martin, L. H. . . . 2626 W. Wash. (22)
 Martz, Bill L. . . . General Hosp. (7)
 Martz, Carl D. . . . 508 Hume Mansur Bldg. (4)
 Marvel, R. J. 3311 N. Meridian (8)
 Masters, John M. . . . 805 Hume Mansur Bldg. (4)
 Masters, Robert J. . . . 805 Hume Mansur Bldg. (4)
 Matthew, W. Burleigh . . 520 Hume Mansur Bldg. (4)
 Matthews, B. J. . . . 4612 E. 10th (1)
 Matthews, W. M. . . . 4612 E. 10th (1)
 Meador, Eric B. . . . 1739 N. Holmes Ave. (22)
 Megenhardt, D. S. . . . 1015 Hume Mansur Bldg. (4)
 Meiks, Lyman T. . . . Riley Hosp. (7)
 Melloh, A. F. . . . 2821 E. 10th (1)
 Mendelson, Stanley M. . . General Hosp. (7)
 Mendenhall, Clarence D. . 4502 E. Wash. (1)
 Mentendiek, Maurice H. . . 205 Hume Mansur Bldg. (4)
 Mericle, Earl W. . . . 920 Hume Mansur Bldg. (4)
 Merrell, Paul 914 Hume Mansur Bldg. (4)
 Mertz, H. O. . . . 1711 N. Capitol (7)
 Mertz, John H. O. . . . 1711 N. Capitol Ave. (7)
 Micheli, Arthur J. . . . 920 Underwriters Bldg. (4)
 Middleton, H. N. . . . 1828 N. Ill. (2)
 Miller, J. Don 514 Hume Mansur Bldg. (4)
 Miller, R. S. 6211 College (20)
 Miller, Wallace E. . . . 510 Hume Mansur Bldg. (4)
 Millikan, William J. . . . 3736 N. Delaware (5)
 Mitchell, E. H. . . . 1023 King (22)
 Mitchell, Edward O. . . . 5704 N. Keystone (20)
 Modjeska, Gerald S. . . . I.U. Medical Center (7)
 Moenning, Walter P. . . . 618 K. of P. Bldg (4)
 Molt, William F. (S) . . . 529 Bankers Tr. Bldg. (4)
 Montgomery, William F. . . 904 Hume Mansur Bldg. (4)
 Moore, Ben B. . . . 414 Hume Mansur Bldg. (4)
 Moore, H. T. . . . 3220 N. Sharon (22)
 Morchan, Saml. . . . 3769 College (5)
 Morgan, Margaret E. . . . I.U. Medical Center (7)
 Moriarty, John R. . . . 5602 Madison (3)
 Morrison, Lewis E. . . . 603 Hume Mansur Bldg. (4)
 Morton, Walter P. . . . 623 Hume Mansur Bldg. (4)
 Moser, Rollin H. . . . 400 Hume Mansur Bldg. (4)
 Mosier, Jack M. . . . 2210 N. Kitley Ave. (18)
 Moss, Bobby L. . . . 4533 E. 21st St. (18)
 Moss, H. B. 1849 Nowland Ave. (1)
 Moss, Herschel C. . . . I.U. Medical Center (7)
 Mothersill, M. H. . . . 3650 College Ave. (5)
 Moulton, L. G. . . . 1327 N. Penn. (2)
 Mueller, L. B. . . . 4026 Broadway (5)
 Muller, L. P. 3120 N. Meridian (8)
 Muller, P. F. 3311 N. Meridian (8)
 Muller, Victor H. . . . 1512 N. Meridian (2)
 Mumford, E. B. 320 N. Meridian (4)
 Myers, Chas. W. R. 2, Box 256 (24)
 Myers, R. V. . . . 1904 N. Rural (18)
- N
- Nafe, Cleon A. . . . 822 Hume Mansur Bldg. (4)
 Nagan, Robert F. . . . 606 Hume Mansur Bldg. (4)
 Nay, Richard M. . . . 1007 Hume Mansur Bldg. (4)
 Need, L. T. . . . 1927 S. Meridian (25)
 Neier, O. C. (S) 5506 E. Wash. (19)
 Nester, H. G. . . . Room 307, City Hall (4)
 Nie, Louis W. . . . 2901 N. Meridian St. (8)
 Nielsen, Juul C. . . . 1315 W. 10th St. (2)
 Noble, Thomas B., Jr. . . 1008 Hume Mansur Bldg. (4)
 Nolting, H. F. . . . 261 W. 40th (8)
 Norman, Olin B. . . . 922 Hume Mansur Bldg. (4)
 Norman, William H. . . . 908 Hume Mansur Bldg. (4)
 Norris, Howard Lee . . . 704 Hume Mansur Bldg. (4)
 Norris, Max S. . . . I.U. Medical Center (7)
 Nourse, M. H. 1711 N. Capitol (7)
 Nugent, E. J. Allison Div. GMC (6)
- O
- O'Brian, Earl J. . . . 2425 E. 38th St. (18)
 Ochsner, H. C. Methodist Hosp. (7)
 O'Dell, Thomas A. . . . 3627 N. Penn. St. (5)
 Offutt, Andrew 1330 W. Michigan St. (7)
 O'Malley, Martha 1330 W. Michigan St. (7)
- Olvey, O. N. . . . 3769 Park Ave. (5)
 Orders, Clark E. . . . 440 Bankers Tr. Bldg. (4)
 Otten, Claude F. . . . 812 C. of C. Bldg. (4)
 Ottinger, Ross C. . . . 912 Hume Mansur Bldg. (4)
 Owen, John E. . . . 605 Hume Mansur Bldg. (4)
 Owens, T. C. 2823 N. Meridian (8)
 Owens, Walter L. . . . I.U. Medical Center (7)
- P
- Pandolfo, Harry 2206 Madison (25)
 Parker, G. F., Jr. . . . 1517 N. Emerson (19)
 Parker, J. F. . . . 1706 E. Wash. (1)
 Parker, Portia 2226 W. Mich. (22)
 Patton, M. T. . . . 107 W. 30th (8)
 Paulissen, G. T. 741 Markwood (27)
 Pearson, Lyman R. . . . 311 Hume Mansur Bldg. (4)
 Pebworth, Aubrey C. (S) . . 1625 W. Morris (21)
 Peck, F. B. . . . 740 S. Alabama (6)
 Peirce, J. D. . . . Eli Lilly & Co. (6)
 Pennington, Walter E. . . . 214 Hume Mansur Bldg (4)
 Permer, Erwin . . . 136 E. 30th (5)
 Petranoff, T. V. 3367 W. Mich. (22)
 Pettijohn, Fred L. (S) . . . 2460 Central (5)
 Pfaff, Dudley VA Regional Office (4)
 Phillips, David L. . . . 1800 E. Tenth St. (1)
 Pickett, Robert D. . . . 400 Hume Mansur Bldg. (4)
 Pierce, William J. . . . General Hosp. (7)
 Pilcher, Jack E. . . . 201 Hume Mansur Bldg. (4)
 Pietz, David G. . . . 1801 E. 34th St. (18)
 Plautz, Geraldine Z. . . . 820 N. Bradley (1)
 Pollak, Lewis . . . 1602 N. Penn. (2)
 Popplewell, Arvine G. . . . Sunnyside Sanitarium
 Porter, Dale . . . 1481 W. 10th St. (2)
 Prather, Philip E. . . . General Hosp. (7)
 Price, Francis W. . . . 2020 Madison Ave. (25)
 Price, James O. . . . 906 Hume Mansur Bldg. (4)
 Pryor, R. C. . . . 6111 College (20)
- Q
- Quigley, Jos. B. . . . 4590 E. Kessler Blvd.
- R
- Rabb, Frank M. . . . 624 Hume Mansur Bldg. (4)
 Rabb, H. S. . . . 3139 E. 10th (1)
 Rader, George S. . . . 1010 Hume Mansur Bldg. (4)
 Radigan, L. R. I.U. Med. Center (7)
 Ralston, John D. . . . 6349 Guilford Ave. (20)
 Ramsey, Frank B. . . . 201 Hume Mansur Bldg. (4)
 Reed, Barbara Anne . . . General Hosp. (7)

MARION COUNTY

(Indianapolis—Continued)

- Reed, Jewett V. (S)
820 C. of C. Bldg. (4)
- Reed, Philip B. . . . 1800 E. 10th (1)
- Rees, R. C. 6114 E. Wash. (19)
- Reid, Chas. A. 2445 Shelby (3)
- Reisler, Simon
318 Bankers Tr. Bldg. (4)
- Rhodes, Theodore D.
307 Hume Mansur Bldg. (4)
- Rice, R. M. 740 S. Alabama (6)
- Richardson, Thad T.
513 S. Sherman Dr. (3)
- Richter, Arthur B.
720 Hume Mansur Bldg. (4)
- Ricketts, J. W.
2901 N. Meridian St. (8)
- Ridgeway, O. W. (S)
411 E. 16th (2)
- Rigg, John F.
421 Hume Mansur Bldg. (4)
- Rinker, Earl B. 22 E. 57th St.
- Ritchey, James O.
608 Hume Mansur Bldg. (4)
- Ritter, Wayne L.
404 Hume Mansur Bldg. (4)
- Robb, John A.
238 Hume Mansur Bldg. (4)
- Robertson, R. B. 6118 E. Wash. (19)
- Rogers, Donald L.
3311 N. Meridian St. (8)
- Rohn, Robert J.
420 Hume Mansur Bldg. (4)
- Roller, C. W. 1437 Shelby (3)
- Romberger, F. T., Jr.
3440 N. Meridian (8)
- Rosenak, Bernard D.
226 Hume Mansur Bldg. (4)
- Rosenbaum, David
1481 W. 10th St. (2)
- Rosenbaum, Irving, Jr.
401 E. 34th St. (5)
- Ross, A. T. I.U. Med. Center (7)
- Roth, Bertram
6378 College Ave. (20)
- Row, D. Hamilton
906 Hume Mansur Bldg. (4)
- Rubin, Gerald S.
624 Hume Mansur Bldg. (4)
- Ruddell, Karl R.
3202 N. Meridian (8)
- Ruddell, Keith R.
3202 N. Meridian (8)
- Rudesill, Cecil L.
405 Hume Mansur Bldg. (4)
- Rudesill, Robert
721 Clarendon Rd. (8)
- Rupel, Ernest
419 Hume Mansur Bldg. (4)
- Rust, B. K. 3740 Central (5)
- Ruth, M. L. 4304 E. Wash. (1)
- Rutherford, C. W. (S)
4601 N. Penn. (5)
- Rutherford, Charles E.
6567 E. Raymond (44)
- Ryan, G. V. 2428 W. 16th (22)
- S
- Sacks, Harry J. 1481 W. 10th (2)
- Sage, Russell A.
505 Hume Mansur Bldg. (4)
- Salb, Max C. 826 C. of C. Bldg. (4)
- Salzman, Morris
1119 S. Meridian (25)
- Sanders, Harry M.
3760 N. Sherman Dr. (18)
- Sandorf, Marvin 1102 Prospect (3)
- Schaefer, C. Richard (S)
224 N. Meridian, No. 20 (4)
- Schechter, John S.
3209 N. Meridian (8)
- Scheier, E. W. . . . 1542 Prospect (3)
- Schlaegel, T. F., Jr.
624 Hume Mansur Bldg. (4)
- Schlegel, Donald M.
1015 Hume Mansur Bldg. (4)
- Schmidt, L. F.
605 Hume Mansur Bldg. (4)
- Schmidt, R. H.
268 Blue Ridge Rd. (8)
- Schneider, C. J. 1008 N. Beville (1)
- Schuchman, Abe
5878 Washington Blvd. (20)
- Schuchman, Gabriel
3451 College (5)
- Schuster, Dwight W.
723 Hume Mansur Bldg. (4)
- Scott, Geo. 3636 Layman Ave. (18)
- Scott, I. W. . . . 3209 N. Meridian (8)
- Scott, John R. . . . 510 E. 38th (5)
- Scott, R. P.
209 Hume Mansur Bldg. (4)
- Scott, S. L.
6325 Guilford Ave. (20)
- Seagle, William C.
3464 Guilford Ave. (5)
- Seaman, Charles F.
1010 Hume Mansur Bldg. (4)
- Sedam, H. L. . . . 4173½ College (5)
- Segar, Louis H.
633 E. 38th St. (5)
- Seitz, Philip F. D.
I.U. Med. Center (7)
- Sexson, H. T.
5455 N. Meridian (8)
- Shafer, Marion R.
614 Hume Mansur Bldg. (4)
- Sheehan, F. G. 6016 E. Wash. (19)
- Sherster, H. 1135 S. Meridian (25)
- Shrigley, Edward W.
I.U. Med. Center (7)
- Shugart, Joseph A.
St. Vincent's Hosp. (7)
- Shullenberger, W. A.
3740 Central (5)
- Shumacker, Harris B., Jr.
I.U. Med. Center (7)
- Sicks, Okla W.
606 Hume Mansur Bldg. (4)
- Sidebottom, Earl
507 Hume Mansur Bldg. (4)
- Siekerman, C. W. 2612 Madison (3)
- Siersdorfer, Theodore N.
6003 W. Wash. (21)
- Sigmond, Harvey W.
301 Hume Mansur Bldg. (4)
- Simms, J. Leon
2638½ Northwestern (23)
- Simpson, W. D.
6062 Lowell Ave. (18)
- Sims, J. Lawrence
809 Hume Mansur Bldg. (4)
- Sluss, D. H. . . . 808 C. of C. Bldg. (4)
- Sluss, John W. (S)
808 C. of C. Bldg. (4)
- Smith, D. J.
817 Hume Mansur Bldg. (4)
- Smith, David L.
2901 N. Meridian St. (8)
- Smith, E. Rogers
822 Hume Mansur Bldg. (4)
- Smith, F. C. 983 N. Arlington (19)
- Smith, Jas. M.
200 Terminal Bldg. (4)
- Smith, Jay W. . . . Eli Lilly & Co. (6)
- Smith, Lester A.
238 Hume Mansur Bldg. (4)
- Smith, Roy Lee
707 Underwriters Bldg. (4)
- Smith, W. F. . . . 3424 College (5)
- Smith, William B.
2229 Northwestern (23)
- Snider, Byron. . . 2717 S. East (3)
- Solomon, Reuben A.
414 Hume Mansur Bldg. (4)
- Souter, M. C. 3360 N. Meridian (8)
- Sovine, J. W.
720 Hume Mansur Bldg. (4)
- Spahr, John F., Jr.
902 Hume Mansur Bldg. (4)
- Spalding, Joseph J.
706 Hume Mansur Bldg. (4)
- Sparks, Alan L.
1024 Hume Mansur Bldg. (4)
- Spencer, Hugh B.
I. U. Medical Center (7)
- Spivey, R. J. . . . 2616 N. Penn. (5)
- Spolyar, L. W. . . 1330 W. Mich. (7)
- Sputh, Carl B., Jr.
301 Doctors Bldg. (4)
- Sputh, Carl B., Sr.
301 Doctors Bldg. (4)
- Stadler, H. E. . . 5508 E. Wash. (19)
- Stanley, J. S. . . . 307 City Hall (4)
- Staten, Jesse C.
Methodist Hosp. (7)
- Stayton, Chester A., Jr.
313 Hume Mansur Bldg. (4)
- Stayton, Chester A., Sr.
313 Hume Mansur Bldg. (4)
- Stephens, D. E. 6332 Guilford (20)
- Stephens, K. H.
501 Hume Mansur Bldg. (4)
- Stern, Nathan
3753 N. Meridian, No. 201 (8)
- Stevens, S. L.
303 Hume Mansur Bldg. (4)
- Sthair, Phillip L.
General Hospital (7)
- Stoelting, V. K.
I.U. Med. Center (7)
- Stone, A. T. . . . 6202 College (20)
- Stone, David F.
725 Hume Mansur Bldg. (4)
- Storey, D. Edmund
813 Broad Ripple Ave. (20)
- Storey, Jos. L. . . . 3434 N. Ill. (8)
- Storms, Roy B.
5041 Central Ave. (5)
- Strange, Dempsey C.
3509 N. Layman (18)
- Stroup, T. J. 216 K. of P. Bldg. (4)
- Stucky, E. K. . . . 1349 Madison (25)
- Stump, Thomas A.
127 Blue Ridge Rd. (8)
- Stygall, James H.
1221 N. Delaware (2)
- Sudranski, Herbert F.
824 Hume Mansur Bldg. (4)
- Sutton, William E.
419 Hume Mansur Bldg. (4)
- Swan, John R.
915 Hume Mansur Bldg. (4)
- Swayne, J. F. . . . 1410 E. Wash. (1)

MARION COUNTY

(Indianapolis—Continued)

Symmes, Alfred T.
605 E. Maple Rd. (5)
Szynal, Jno. S. 633 E. 38th St. (5)

T

Talbott, Dan E.
1020 Hume Mansur Bldg. (4)
Tanner, Henry S.
301 Hume Mansur Bldg. (4)
Taube, Jack I.
512 Hume Mansur Bldg. (4)
Taylor, Clifford C.
St. Vincent's Hosp. (7)
Taylor, Frederic W.
400 Hume Mansur Bldg. (4)
Teague, Frank W.
918 Hume Mansur Bldg. (4)
Teixler, Victor A.
224 Hume Mansur Bldg. (4)
Test, Charles E.
1002 Hume Mansur Bldg. (4)
Teter, George V. 401 E. 34th (5)
Tether, J. E. I.U. Med. Center (7)
Tharpe, Ray 3202 N. Meridian (8)
Thatcher, Hugh K., Jr.
110 W. Maple Rd. (8)
Thom, J. W. VA Reg. Office (4)
Thom, Julia S. VA Reg. Office (4)
Thomas, Edw. P.
820 W. Michigan St.
Thomas, Fred A.
St. Vincent's Hosp. (7)
Thomas, L. I.
1008 Hume Mansur Bldg. (4)
Thomas, Morris E.
445 N. Penn., No. 715 (4)
Thompson, Charles F.
818 Hume Mansur Bldg. (4)
Thompson, John V.
1221 N. Delaware (2)
Thompson, Paul D.
404 Hume Mansur Bldg. (4)
Thornburg, Kenneth E.
1015 Hume Mansur Bldg. (4)
Thornton, H. C.
3769 College Ave. (5)
Thrasher, John R.
823 C. of C. Bldg. (4)
Thurston, H. S. (S)
2503½ Prospect (3)
Tindall, George T.
6002 Windsor Drive (18)
Tinney, William E. (S)
900 Underwriters Bldg. (4)
Tinsley, Frank W.
603 K. of P. Bldg. (4)
Tinsley, Walter B., Jr.
3314 Carrollton (5)
Tinsley, Walter B.
603 K. of P. Bldg. (4)
Tischer, E. Paul
208 Hume Mansur Bldg. (4)
Torrella, J. A. 5324 W. 16th (24)
Tosick, William A.
5662 Crestview Ave. (20)
Toumey, Fred L.
529 Bankers Tr. Bldg. (4)
Trusler, Harold M.
408 Hume Mansur Bldg. (4)
Tuchman, J. H. 845 Grove (3)
Tucker, R. L. Eli Lilly & Co. (6)
Tucker, Warren S.
414 Hume Mansur Bldg. (4)
Tyner, Harlan H.
3202 N. Meridian St. (8)

V

Vandivier, Robert M.
209 Hume Mansur Bldg. (4)
Van Dorn, Myron J.
3626 Clifton (23)
Van Fleet, Josephine
VA Hosp., 2601 Cold Springs Rd.
Van Meter, C. P. 3419 E. 10th (1)
Van Nuys, John D.
I.U. Med. Center (7)
Van Nuys, Walter C. (S)
Continental Hotel
Van Osdol, Harry A.
828 C. of C. Bldg. (4)
Van Tassel, Charles J.
521 E. 60th St. (20)
Van Vactor, Helen D.
226 Hume Mansur Bldg. (4)
Vellios, Frank
I. U. Medical Center (7)
Vollrath, V. J. 5202 N. Ill. (8)
Von Der Haar, Gerard
4016 E. Michigan
Voyles, Charles F. (S)
715 Underwriters Bldg. (4)

W

Waldo, J. Thayer
610 Hume Mansur Bldg. (4)
Walker, Frank C.
414 Hume Mansur Bldg. (4)
Walker, Robt. K. 413 E. 34th (5)
Walther, J. E. 3202 N. Meridian (8)
Ward, Joseph H.
2116 Boulevard Pl. (2)
Ward, W. C. 116 E. 49th (5)
Warfel, F. C.
VA Regional Office (9)
Warman, Alvah P.
1363 E. 38th St. (5)
Warriner, James B.
975 N. Emerson Ave. (19)
Warvel, John H.
614 Hume Mansur Bldg. (4)
Waymire, E. S. 1827½ College (2)
Wehrman, Jule O. (S)
4263 Washington Blvd. (5)
Weigand, C. G. 740 S. Alabama (6)
Weil, H. J. 443 N. Hamilton (1)
Weinland, George C.
2934 E. 39th St. (5)
Weiss, Jason 4914 W. 16th (24)
Weller, Charles A.
3720 N. Delaware St.
West, Jos. L. 6318 W. Wash. (21)
Westfall, B. K. 2901 E. 38th (18)
Westfall, John B.
2961 N. Sherman Dr. (18)
Weyerbacher, A. F.
663 E. 27th St. (5)
White, Donald J.
502 Bankers Tr. Bldg. (4)
White, John B.
812 C. of C. Bldg. (4)
Whitehead, John M.
1544 Roosevelt (1)
Wilkens, I. W. 1743 Shelby (3)
Williams, Chas. D. 2405 Station (1)
Williams, Clifford L.
Central State Hospital
Williams, Howard S.
115 E. 16th St. (2)
Williams, Hugh L.
812 C of C Bldg. (4)
Wilmore, Ralph C.
I.U. Med. Center (7)
Wilson, Fred M.
I.U. Medical Center (7)

Wilson, O. R. 3519 Wash. Blvd. (5)
Winters, Matthew 508 E. 38th (5)
Wise, Wm. 120 E. 22nd (2)
Wise, William R.
General Hospital (7)
Wishard, Wm. Niles, Jr.
1711 N. Capitol (7)
Wolfram, Don J.
208 Hume Mansur Bldg. (4)
Wood, D. E. 6325 Guilford (20)
Woodall, Earl C.
3426 N. Meridian (8)
Woodard, A. S., Jr.
668 E. Maple Rd. (5)
Woolling, Kenneth R.
718 Hume Mansur Bldg. (4)
Worley, J. P. 3705 N. Denny (18)
Worley, Richard H.
6016 E. Washington St. (19)
Wright, J. William, Jr.
301 Hume Mansur Bldg. (4)
Wright, J. William, Sr.
301 Hume Mansur Bldg. (4)
Wytttenbach, F. C. 1154 Lee (21)
Wytttenbach, John E.
503 Hume Mansur Bldg. (4)

Y

Yochem, August S.
1315 W. 10th St. (7)
Young, John E.
812 C. of C. Bldg. (4)
Young, J. M. 3209 N. Meridian (8)
Young, J. W. 6302 Guilford (20)
Young, W. C.
428 Bankers Trust Bldg. (4)

Z

Zell, E. H. 812 C. of C. Bldg. (4)
Zerfas, C. P. A. 2605 Shelby (3)
Zerfas, Phyllis K. 2605 Shelby (3)
Bartle, James L. Lawrence
Lewis, Robert J. Lawrence
Asher, E. O. New Augusta
Asher, James W. New Augusta
Paynter, Morris B. Southport
Jones, George L. Wanamaker
Berton, William M.
887 Louise Circle, Durham, N.C.
Bock, Don G.
38 Woodward, Battle Creek, Mich.
Brockmeier, F.
404 Union Central Bldg.,
Cincinnati, O.
Bowman, Harold E.
11214 Glenfield Ave.,
Detroit, Mich.
Butler, Robert M.
Hq. Sq. 6154th A.B.G. Med. Sec.,
A.P.O. 770, San Francisco, Calif.
Carlson, Charles E.
9856 S. Seeley Ave., Chicago, Ill.
Caseley, Donald J.
922 E. 84th St., Chicago, Ill.
Connerley, Marion L.
3762 La Cresta Dr.,
San Diego, Calif.
Cure, Charles
149-I Wherry Housing,
Fort Campbell, Ky.
Deer, Blam F.
312 Fordham Dr.,
Lake Worth, Fla.
Dester, Herbert E.
Jagdeeshpur Via Raipur,
C. P. India

MARION COUNTY**(Continued)**

Donner, Paul G.
Hartford Retreat, Hartford, Conn.
Dryden, Gale E.
Box 15, Fort Totten, N. Dakota
Eckert, Russell A.
Ill. Masonic Hosp., Chicago, Ill.
Fisher, Gerald
1120 Chester Ave., Cleveland 14, O.
Fisk, Frank B.
36 Kerwin Pl., Tarrytown, N. Y.
Friedman, David K.
4714 Crawford, Houston, Texas
Gaskill, Herbert S.
250 Ash St., Denver, Colo.
Glendenning, Richard L.
Box 993, Springfield, Ill.
Graf, John E. . . . 4332 N. Kilbourn
Ave., Chicago 41, Ill.
Gregory, Charles F.
c/o Fleet P. O.
San Francisco, Calif.
Griswold, Wait Robbins
U. S. Naval Hosp.,
San Diego, Calif.
Gunderson, Shaun D.
5120 Leavenworth St., Omaha,
Neb.
Guthrie, James U.
Nellis A.F.B., Nevada
Harvey, Verne K.
39 River Road Terrace,
Alexandria, Va.
Heinz, Dorothy C. V.
Johns Hopkins Hosp.,
Baltimore, Md.
Houseworth, John H.
2200 Hanover, Aurora, Calif.
Kopp, Herschel S.
116 Via La Circular,
Redondo Beach, Calif.
Langdon, J. Ray
310 W. 21st St., Pueblo, Colo.
Lanning, R. Adrian
Memorial Hosp., Phoenix, Ariz.
Littlefield, Paul A.
A.P.O. 309, San Francisco, Calif.
Loehr, William M.
97 S. Lyman St., Waltham, Mass.
Lomax, Claude C.
276 Santa Isabel, Costa Mesa, Calif.
MacDonald, John A. (S)
Interlaken, N. Y.
McKechnie, Franklin B.
23 Emerick Lane,
Watervliet, N. Y.
Kilmer, Warren L.
International Falls, Minn.
Manning, Joseph C.
403 Wilson Dr.,
Midwest City, Okla.
Mather, Robert
309 D Croyden, BMV,
San Antonio, Texas
Mitchell, Raymond E.
O'Reilly Veterans Hosp.,
Springfield, Mo.
Moree, George J.
Smoky Hill A.F.B., Kansas
Murray, James S. 606 N. Roxbury,
Beverly Hills, Calif.
Norris, Mary Alice
Carlisle, Tenn.
Norwick, Sydney S.
15816 Via Riveria,
San Lorenzo, Calif.

MARION COUNTY**(Continued)**

Osborne, Harry S. (S)
R. 1, Box 337, Leesburg, Fla.
Raber, Robert M.
4491 Osprey, San Diego, Calif.
Rice, Frederic A.
Station Hosp., Roswell, N. Mex.
Robinson, Frank C.
14301 Bay Dr.,
St. Petersburg 6, Fla.
Rogers, Thomas P.
U.S.N. Hosp., Philadelphia, Pa.
Rudolph, Stephen J.
Scott A.F.B., Ill.
Seidell, Martin A.
Mayo Clinic, Rochester, Minn.
Soper, Hunter A. . . 1605 E. 7th St.,
Emmettsburg, Iowa
Spencer, Hugh B. . . . Tulsa, Okla.
Tetrick, Elbert L.
1726 Orrington Ave., Evanston,
Ill.
Tharp, Harold R. . . . Xenia, Ohio
Thomas, Ralph G.
Fort Custer, Mich.
Topek, Nathan H.
3902 Med. Grp., Offutt AFB, Neb.
Turrell, Eugene S.
Univ. of Colorado, Denver, Colo.
White, Philip T.
Mayo Clinic, Rochester, Minn.
Wilson, Douglas E.
Percy Jones Hosp.,
Battle Creek, Mich.
Ziperman, H. Haskell-M.C. O-63149
141 Gen. Hosp., A.P.O. 1005
c/o P.M., San Francisco, Calif.

MARSHALL COUNTY

Kelly, Frank Argos
Sheller, Thomas G. Argos
Connell, Vactor O. Bourbon
Marshall, George L. Bourbon
Bowen, Otis Bremen
Cripe, Earl P. Bremen
Schreiner, John E. Bremen
Stine, Marshall E. Bremen
Baker, Milan D. Culver
Bills, L. F. R.R. 1, Culver
Witham, Robert L. Culver
Connell, Paul S. Plymouth
Danielson, Harry E., Jr. . . . Plymouth
Irey, Paul R. Plymouth
Klingler, Maurice O. . . . Plymouth
Kubley, James Plymouth
Pomeroy, Rex K. Plymouth
Reed, Robert G., Jr. . . . Plymouth
Robertson, James S. . . . Plymouth
Vore, L. W. Plymouth
Thompson, Alfred A. (S) . . . Tyner

MARTIN COUNTY**(See Daviess-Martin)****MIAMI COUNTY**

Shrock, Ethan E. Amboy
Line, Homer E. Chili
Frybarger, Samuel S. . . . Converse
Malott, Frederick R. . . . Converse
Sennett, Wm. K. Macy
Waite, Earl L. (S)
Gilead Mail Macy
Rendel, Harold E. Mexico
Barnett, Ralph E. Peru
Berkebile, John B. Peru
Burrous, E. L. Peru

MARION COUNTY**(Continued)**

Carlson, E. A. (S) Peru
Ferrera, Donald W. Peru
Ferrara, Samuel J. Peru
Herd, C. R. Peru
Johnson, Owen Peru
Lewis, Leonard D. Peru
Lynn, Frank M. (S) Peru
Malouf, Stephen D. Peru
Person, Theodore Peru
Wildman, Roscoe E. Peru
Yarling, John E. (S) Peru

MONROE COUNTY**(See Owen-Monroe)****MONTGOMERY COUNTY****Crawfordsville**

Alexander, Stephen J.
306 Ben Hur Bldg.
Ball, T. Z. (S)
403 Ben Hur Bldg.
Burks, Jess Edwin
411 S. Walnut St.
Cooksey, Thomas L. (S)
109½ S. Washington St.
Cornell, Robert A.
219 Ben Hur Bldg.
Daugherty, Fred N. 120 W. Pike St.
Dodds, Wemple . . . Culver Hospital
Haller, Thomas C.
411 Tinsley Ave.
Humphreys, John W.
312 Jones Ave.
Kinnaman, Howard A.
206 Ben Hur Bldg.
Kirtley, James M.
416 Ben Hur Bldg.
Lingeman, Byron N.
419 Ben Hur Bldg.
Mount, Wm. M. 413 Ben Hur Bldg.
Peacock, Norman F.
219 Ben Hur Bldg.
Pierson, Robert H. 305 E. Main St.
Sharp, John L. . . 219 Ben Hur Bldg.
Wallace, Hawthorne C.
411 Tinsley Ave.
Otten, Ralph E. Darlington
Blix, Fred M. Ladoga
Denny, Frank T. Ladoga
Davis, William New Market
Kindell, Hurschell D.
New Richmond
Hendrix, Claude A. . . . Waveland
Johnson, Frank D. Waynetown
Parker, Carl B. Wingate

MORGAN COUNTY

Alexander, P. M. Martinsville
Bothwell, Camden G. . . Martinsville
Eisenberg, David A. . . Martinsville
Farr, James C. Martinsville
Gibbs, Joseph W. Martinsville
Gray, Leon Martinsville
Miller, Ray D. Martinsville
Pitkin, Edward M. . . . Martinsville
Pitkin, McKendree C. . . Martinsville
Sweet, Edward M. (S) . . Martinsville
Van Wienen, John Martinsville
Willan, Horace R. . . . Martinsville
Murphy, Maurice G. . . Morgantown
Seibel, Robert Morgantown
Comer, Charles W. . . . Mooresville
Comer, Jonathan (S) . . Mooresville
Comer, Kenneth E. . . . Mooresville

MORGAN COUNTY (Continued)

Karpel, Bernard Mooresville
VanBokkelen, Robert W. Mooresville

NEWTON COUNTY (See Jasper-Newton)

NOBLE COUNTY

Bowman, Charles M. Albion
Nash, Justin R. Albion
Mattmiller, Everette D. Avilla
Sneary, Kenneth D. Avilla
Veazey, Wm. M. (S) Avilla
Bryan, Robert E. Kendallville
Goodwin, Columbus B. (S) Kendallville
Gutstein, Richard R. Kendallville
Lawson, Isaac H. Kendallville
Messer, Frank W. Kendallville
Munk, Cleorie E. Kendallville
Seybert, Joseph D. Kendallville
Stallman, Carl F. Kendallville
Williams, Harold O. Kendallville
Young, Simon J. (S) Kendallville
Schutt, James B. Ligonier
Stultz, Quentin F. Ligonier
Webster, Paul L. Ligonier
Fipp, August L. Rome City
Pulskamp, Bertrand H. Wolcottville

Luckey, Harold A. Wolf Lake
Luckey, Robert C. Wolf Lake
Roth, James R. Wolf Lake
Switzer, Robert E. U.S. Naval Hosp., Bethesda, Md.

OHIO COUNTY

(See Dearborn-Ohio)

ORANGE COUNTY

Keseric, Nicholas E. French Lick
Sugarman, Benj. E. French Lick
Take, John F. (S) French Lick
Colglazier, Granville G. Leipsic
Baker, Robert E. (S) Orleans
Hodgin, Philip Orleans
Schoolfield, Wm. E. Orleans
Clark, Ivan A. Paoli
Hammond, Keith Paoli
Knox, Edwin S. Paoli
Spears, John K. Paoli
Teaford, Schuyler F. (S) Paoli
Boyd, Clarence E. West Baden
Miller, Henderson L. (S) West Baden

OWEN-MONROE COUNTIES

Bloomington

Austin, Fred H. (S) .110 E. 4th St.
Baxter, Neal E. 306 E. 5th St.
Bidney, Evelyn B. .214 E. Kirkwood
Borland, Raymond M. 114 N. Lincoln St.
Buckingham, Richard E. 344 College Ave.
Culmer, Walter N. (S) 432 S. College Ave.
Dalton, Naomi L. 114 E. 7th St.
DeMotte, Russell. 403 N. Walnut
Estes, Ambrose C. .300½ E. 5th St.

OWEN-MONROE COUNTIES

(Bloomington—Continued)

Fowler, Richard R. 108 S. Washington
Geiger, Dillon D. 300 E. Kirkwood
Hardtke, Eldred F. Indiana University
Hepner, Herman S. .312 N. Walnut
Holland, Charles E. 712 N. Washington St.
Holland, Deward J. (S) 313 N. College Ave.
Holland, Philip T. 108 W. 7th St.
Karsell, William A. 306 East Kirkwood
Link, William C. 110 S. Washington St.
Luzadder, John E. (S) 123½ W. 5th St.
Lyons, Robert E. 321 E. 5th St.
Marchant, Clarence H. 350 S. College
McLelland, Mary Rhamy R.R. 2
Middleton, Thos. O. 404 E. 7th St.
Miller, Mary E. 701 E. 10th St.
Owen, Abraham M. 200 S. Washington St.
Owen, Margaret A. 200 S. Washington St.
Pizzo, Anthony Bloomington Hosp.
Poolitson, George C. 407 N. Walnut St.
Quarles, E. Bryan Indiana Univ.
Ramsey, Hugh S. 307 E. 5th St.
Reed, William C. 307 E. 5th St.
Rieger, I. Taylor 108 S. Washington St.
Rogers, Otto F., Jr. 210 N. Washington St.
Rollins, Thomas K. 114 E. 7th St.
Ross, Ben R. 314 E. 7th St.
Schell, Harry D. 114 E. 4th St.
Schuman, Edith B. Indiana University
Sibbitt, Joseph W. 300 E. 5th St.
Smith, Herschel S. 110 S. Lincoln
Smith, Paul E. 812 North College
Smith, Rodney D. (S) 115 N. Washington St.
Spencer, Beaufort A. 114 N. Lincoln
Stangle, William J. Bloomington Hospital
Taylor, Eugene E. 1040 Maxwell Lane
Topoligus, James N. 403 N. Walnut St.
Tripp, Harry D. 205 S. Walnut St.
Wellpott, Jean Franklin Indiana University
Wilson, Talmage L. 301 E. Kirkwood

Brown, Frederick R. Ellettsville
Holtzman, Paul W. Gosport
Stouder, Charles E. Gosport
Mitchell, George L. Smithville
Brown, Marcel S. Spencer
Greene, Claude D. Spencer
Kay, Oran E. Spencer
Smith, Frederick R. Spencer

PARKE-VERMILLION COUNTIES

Greene, Frederick G. Bloomington

Brown, Ralph E. Cayuga
Darroch, Samuel Cayuga
Casebeer, Paul B. Clinton
Evans, Frederick Clinton
Gerrish, Wakefield D. Clinton
Herzberg, Milton Clinton
Kercheval, John M. Clinton
Pickett, Paul Clinton
White, Isaac D. (S) Clinton
Lauer, Dorothy B. Dana
Myers, William C. Dana
Bowman, Ralph Marshall
Gard, Daniel A. Marshall
Britton, Welbon D. Montezuma
Saunders, Jones L. Newport
Johnson, William A. Perrysville
Bloomer, Joseph R. Rockville
Bloomer, Richard S. Rockville
Dowell, Emil H. Rockville
Harstad, Casper Rockville
Merrell, Basil M. Rockville
McGilvray, Eva R. T. Ind. State Sanitarium, Rockville

Pirke, Hubert B. Ind. State Sanitarium, Rockville
Staff, Robert A. Ind. State Sanitarium, Rockville
White, Chester S. Rosedale
Keith, Freeman E. (S) St. Bernice

PERRY COUNTY

Bush, Hargis R. Cannelton
Coults, Porter J. Tell City
Dome, Hardin S. (S) Tell City
Dukes, David Tell City
Glenn, Fred C. Tell City
James, Nicholas A. Tell City
Lashley, Donald L. Tell City
Lohoff, Lewis C. Tell City
Neifert, Noel L. Tell City
Snyder, Earl R. Troy

PIKE COUNTY

Dickinson, Gordon A. Petersburg
Higgins, James L. Petersburg
Kime, John T. (S) Petersburg
Logan, Austin R. (S) Petersburg
Omstead, Milton Petersburg
DeTar, George B. (S) Winslow
Dierdorf, Fred Winslow

PORTER COUNTY

Dale, Joseph W. Chesterton
Griffin, Joseph P. Chesterton
Hall, Thomas C. Chesterton
Harless, Clarence M. Chesterton
Robertson, William C. Chesterton
Ashmore, Herbert C. Hebron
Kleinman, Francis J. Hebron
Dittmer, Jack E. Kouts

Valparaiso

Brown, James C. Farmers State Bank
Davis, Carl M. 202 Indiana Ave.
DeGrazia, Eugene 810 LaPorte Ave.
DeWitt, Charles E. (S) 23 Lincoln Way
Dittmer, Thomas L. (S) 23 Lincoln Way
Douglas, Geo. R. (S) 23 Lincoln Way
Eades, R. Charles 501 E. Lincoln Way

PORTER COUNTY

(Valparaiso—Continued)

Eades, Ralph C. . . . 501 Lincoln Way
 Frank, John R. . . . 23 Lincoln Way
 Green, Leonard J. . . .
 302 E. Lincoln Way
 Makovsky, Theodore
 808 Lincoln Way
 Miller, Ebbo H. . . . 608 Union St.
 Nash, Charles B. . . .
 23 Lincoln Way
 Poncher, Henry G.
 Valparaiso University
 Powell, Edgar H. (S)
 23 Lincoln Way
 VanWinkle, Arthur J. . . 22 Franklin
 Vietzke, Paul C. F. . . . 60 Jefferson
 Gordon, Joseph L.Wheeler
 Adair, Fred L. (H)
 P.O. Box 158, Maitland, Fla.

POSEY COUNTY

Montgomery, Samuel B. (S)
 Cynthiana
 Ropp, Harold E. . . . New Harmony
 Thompson, Lewis R. . . New Harmony
 Boren, PaulPoseyville
 Boren, Samuel W. (S) . . Poseyville
 Woods, Arba L.Poseyville
 Challman, William B. . . Mt. Vernon
 Herr, John W.Mt. Vernon
 Oliphant, Frank W. . . . Mt. Vernon
 Vogel, L. John Mt. Vernon
 Williams, Frederic . . . Mt. Vernon

PULASKI COUNTY

Dublin, Madeline Francesville
 Ives, Raymond J. . . . Francesville
 Linton, Charles E. (S) . Medaryville
 Carneal, Thomas E. . . . Winamac
 Halleck, Harold J. . . . Winamac
 Thompson, William R. . . Winamac
 Yale, Charles A.Winamac

PUTNAM COUNTY

Veach, Lester W.Bainbridge
 Veach, Richard L. . . . Bainbridge
 Gray, Clyde C.Cloverdale
 Huckleberry, Carl D. . . Cloverdale
 Lemmon, Brandt E.
 R. R. 1, Cloverdale
 Dettloff, Frederick . . . Greencastle
 Dobbs, O. R.Greencastle
 Fuson, Wenfred J. . . . Greencastle
 Gillespie, Joseph F. (S)
 Greencastle
 Johnson, James B. . . . Greencastle
 Nichols, Anne Sackett . Greencastle
 Rhea, Gilbert D. . . . Greencastle
 Schauwecker, Cleon M. Greencastle
 Steele, Dick J.Greencastle
 Tennis, George T. . . . Greencastle
 Tipton, William R. . . . Greencastle
 Wiseman, V. Earle . . . Greencastle
 Gwaltney, Loral F. . . . Roachdale
 Richards, Edgar E. . . . Russellville

RANDOLPH COUNTY

Nixon, ByronFarmland
 White, Harvey E. . . . Farmland
 Harmon, Wayne Lynn
 Jordan, Leo E.Lynn

Martin, Charles E.Lynn
 Slick, Crystal R.Lynn
 Shallenberger, Henry R. . . Modoc
 Hinchman, JeanParker
 Henderson, Arvin Ridgeville
 Potter, Richard M. . . . Ridgeville
 Chambers, Leroy B. . . . Union City
 Phipps, Leland K. . . . Union City
 Reid, Robert W.Union City
 Voisinnet, Raymond A. . . Union City
 Wills, Benjamin F. . . . Union City
 Brenner, Ivan E.Winchester
 DeRyke, Gilbert R. . . . Winchester
 Dininger, William S. . . Winchester
 Engle, Russell B. . . . Winchester
 Painter, Lowell W. . . . Winchester
 Robison, John S. . . . Winchester
 Sparks, Paul W. . . . Winchester

RIPLEY COUNTY

Hisrich, Lloyd W.Batesville
 Lippoldt, Charles L. . . . Batesville
 Obery, George A.Batesville
 Conrad, Henry W.Milan
 Hunter, Lowell G.Milan
 Warn, William J.Milan
 Daley, Edward H. . . . Oldenburg
 Row, George S.Osgood
 Smith, R. LeeOsgood
 McConnell, William C. . . Sunman
 Fletcher, Charles F. . . . Sunman
 Hopkins, Lester H. . . . Versailles
 Moran, Noel D.Versailles

RUSH COUNTY

McNabb, George B. . . . Carthage
 Sheets, Charles E. . . . Manilla
 Worth, C. Willard Milroy

Rushville

Atkins, C. C.225 N. Morgan
 Corpe, Kenneth F.Rushville
 Dean, Donald L.310 E. Fifth
 Denny, Melvin H. . . . 127 W. Third
 Ellis, Davis W.229 N. Morgan
 Green, Frank, Jr. . . . 134 E. Second
 Johnson, Robt. B. . . . 229 N. Morgan
 Kennedy, Robt. O. . . . 118 W. Third
 Nutter, W. H.205 W. Third
 DeHaven, Harry E.
 Pleasantville, New York
 Truman, Michael
 Lockbourne A.F. Hosp.,
 Columbus 17, Ohio

ST. JOSEPH COUNTY

Houser, D. Stanley Lakeville
 How, John T. (S) Lakeville
 Smith, LeeLakeville

Mishawaka

Barone, C. V.312 Lincolnway W.
 Bassler, C. R.Mishawaka Tr. Bldg.
 Christophel, Verna . . 109 W. Third
 Duvall, William N.
 117½ Lincolnway E.
 Ganser, Richard A.
 1020 Wilson Blvd.
 Goethals, C. J. . . . 602 Lincolnway W.
 Martin, Charles F. . . 224 S. Mill St.
 Orr, Robert124 S. Race
 Peltier, Hubert C.
 114 Lincolnway, W.
 Rosenwasser, Jacob
 228 Lincolnway East
 Sirlin, Edw. M. . . . 111 S. Church

ST. JOSEPH COUNTY

(Mishawaka—Continued)

Spalding, Wendell L.
 212 First Nat. Bk. Bldg.
 Templeton, A. R. . . . 522 Calhoun St.
 Van Rie, Leo P.116 S. West
 Walerko, Frank 204 Polis Bldg.
 Walters, Charles . . . 207 Polis Bldg.
 Ward, Jas. W.316 Lincolnway W.
 Whitlock, Francis . . 110 N. Race St.
 Whitlock, Merle E. . . 123 W. Fourth
 Wixted, Jno. F. . . . 314 Lincolnway E.
 Wixted, Julia F.
 314 Lincolnway, E.
 Wurster, Herbert C. . . 221 E. Third
 Wygant, Marion D. . . 116 W. Third
 Wyland, Byron J. . . . 116 W. Third
 Zimmer, H. J. . . . 119½ Lincolnway W.

Luzadder, John E., Jr. . New Carlisle
 Hardy, John J. . . . North Liberty
 Warrick, Homer Lyle . . . Osceola

South Bend**A**

Abel, Joseph A. . . . 1222 Western Ave.
 Acker, Robert B.
 418 Sherland Bldg.
 Arisman, Ralph K.
 711 Odd Fellow Bldg.

B

Balla, Morris 404 Sherland Bldg.
 Baran, Charles . . . 710 J.M.S. Bldg.
 Bartsch, Harvey L.

502 J.M.S. Bldg.
 Bechtold, Samuel E.
 730 Sherland Bldg.

Bennett, Jene R. . . . 531 Main St.
 Berke, Robert D.
 102 E. Colfax Ave.

Biasini, Benedict A.
 401 Dixie Way North

Bickel, David A.
 515 Odd Fellows Bldg.

Birmingham, Peter J.
 426 Sherland Bldg.

Bishop, Charles A.
 122 N. Lafayette Blvd.

Bixler, Louis C. . . 615 Sherland Bldg.
 Blackburn, Erwin
 508 Sherland Bldg.

Bodnar, Leslie M.
 525 N. Michigan

Bolka, Bernard . . . 728 W. Colfax
 Borough, L. D. . . . 710 J.M.S. Bldg.

Bosenbury, Charles S. (S)
 323 W. Navarre St.

Brecht, Harvey J.
 1016 W. Washington St.

Bryan, Robert J.
 1002 Lincolnway W.

Buchanan, Wallace D.
 825 Sherland Bldg.

Buechner, Frederick W.
 116 N. Main St.

Bussard, Clifford F.
 202 Whitcomb-Keller Bldg.

Bussard, Frank
 202 Whitcomb-Keller Bldg.

C

Carter, F. R. N. . . . 605 Sherland Bldg.
 Cassady, James V.
 921 Lincoln Way East

Clark, Stanley A. (S)
 1242 E. Jefferson St.

ST. JOSEPH COUNTY

(South Bend—Continued)

Clark, William H.
122 N. Lafayette Blvd.
Colip, George D.
514 Sherland Bldg.
Condit, David H.
122 N. Lafayette Blvd.
Cook, Gordon C.
122 N. Lafayette Blvd.
Cooper, Harry L.
410 Sherland Bldg.
Culbertson, Carl S. 531 N. Main St.
Custer, Edward W.
Healthwin Sanitarium

D

Denham, Robert H.
425 Odd Fellows Bldg.
Dietl, Ernest L. 822 Sherland Bldg.
Dodd, Robert D. 759 Portage Ave.
Dolezal, Bernard J.
315 J.M.S. Bldg.
Donnelly, Everett F.
530 W. Indiana Ave.
Duggan, James A. 110 Peashway
Dunlap, D. Logan 716 J.M.S. Bldg.

E

Ebin, Judah L.
706 Odd Fellow Bldg.
Edwards, Bernard E.
704 N. Main St.
Egan, Sherman 301 Sherland Bldg.
Ellison, Alfred. 826 Sherland Bldg.
English, John P.
122 N. Lafayette Blvd.
Ericksen, Lester G.
615 Sherland Bldg.
Erickson, Gustaf W.
122 N. Lafayette Blvd.

F

Faltin, Ladislaus
609 Odd Fellows Bldg.
Feferman, Martin E.
510 Sherland Bldg.
Feldman, Max. . . . 1921 Miami St.
Firestein, Ben Z. 703 J.M.S. Bldg.
Fish, Clyde M. (S)
723 Sherland Bldg.
Fish, Edson C.
401 N. Notre Dame Ave.
Fisher, Lawrence F.
825 Sherland Bldg.
Frank, Lyall L. . . . 534 N. Lafayette
Frash, DeVon W. 306 J.M.S. Bldg.
Frey William B. 209 Poledor Bldg.
Friedman, Morris S.
218 Poledor Bldg.
Frith, Gladys
521 W. Washington Ave.
Frith, Louis G.
521 W. Washington Ave.

G

Gates, George E.
122 N. Lafayette Blvd.
Gilman, Marcus M.
403 Odd Fellow Bldg.
Giordano, Alfred S.
531 N. Main St.
Godersky, George E.
512 Odd Fellows Bldg.
Graf, John P. 424 Peashway Ave.

Green, G. F. . . . 822 Sherland Bldg.
Green, Norval E. 704 N. Main St.
Grillo, Donald. 530 Sherland Bldg.
Grorud, Alton C.
120 Lafayette Blvd.

H

Haley, Paul E. . . 401 Sherland Bldg.
Hall, James M. 230 Sherland Bldg.
Hamilton, Chas. D.
1498 Northern Ave.
Harmon, V. E. . . 302 Sherland Bldg.
Haugseth, Ellsworth K.
122 Lafayette Blvd.
Helmen, H. W. . . 120 Franklin Place
Helmer, John F.
826 Sherland Bldg.
Hilbert, J. W. . . 410 W. Washington
Hill, Theodore A.
527 W. Colfax Ave.
Hillman, M. W. 429 Sherland Bldg.
Hillman, W. H. (S)
429 Sherland Bldg.
Hoffman, R. V. 416 Sherland Bldg.
Holdeman, L. S. 404 N. Lafayette
Holdeman, R. W. 404 N. Lafayette
How, Louis E. 6101 S. Michigan
Hyde, C. C. . . . 122 N. Lafayette

J-K

Johns, N. C. . . . 718 Sherland Bldg.
Kamm, B. A. . . . 526 Sherland Bldg.
Karn, John. . . . 728 W. Colfax Ave.
Klahr, Elsworth. 704 N. Main St.
Knapp, Arthur L. 2215 Mishawaka
Knode, K. T. . . . 729 Sherland Bldg.
Kramer, Albert A. . . 1519 Miami
Krueger, John E.
401 N. Notre Dame Ave.
Kuhn, F. L. . . . 1215 S. Michigan

L

Lamb, J. Leonard 730 J.M.S. Bldg.
Lane, William H. . . . 604 N. Main
Lang, Joseph E. 318 Sherland Bldg.
Langenbahn, Carl J.
206 Sherland Bldg.
LaRocca, Joseph. 840 N. Main St.
Lionberger, John R.
615 Sherland Bldg.
Liss, E. C. . . . 317 Odd Fellow Bldg.
Lockhart, Philip B.
825 Sherland Bldg.
Luginbill, Howard M.
3201 Mishawaka Ave.
Luthy, Karl R.
1204 E. Bronson St.

M

Mason, Bernard A.
122 N. Lafayette Blvd.
McCraley, W. J. 406 Sherland Bldg.
McDonald, R. M. 410 J.M.S. Bldg.
McFarland, Corley B.
122 N. Lafayette Blvd.
McKenna, H. J. . . . 1615 E. Wayne
Metcalf, Grant E.
319 Odd Fellow Bldg.
Mikesch, W. H. 816 Sherland Bldg.
Miller, Milo K.
122 N. Lafayette Blvd.
Mott, C. A. 1301½ W. Washington
Mueller, Hilbert M.
122 N. Lafayette Blvd.
Murphy, Eugene C.
122 N. Lafayette Blvd.
Murphy, J. F. . . . 625 J.M.S. Bldg.

N-O

Nelson, F. Dale 428 Sherland Bldg.
Nelson, R. E. . . . 510 Sherland Bldg.
Olson, K. L. . . . 615 Sherland Bldg.

P

Parshall, Dale B.
615 Sherland Bldg.
Parsons, Robert L.
215 Poledor Bldg.
Pauszek, T. B. 726 W. Washington
Petrass, A. . . . 516 Sherland Bldg.
Phelps, Stephen R.
818 Sherland Bldg.
Plain, George
122 N. Lafayette Blvd.
Potter, Thomas P. Jr.
531 N. Main St.
Proudfit, Charles H.
525 Odd Fellow Bldg.
Pyle, H. D. . . . 518 Sherland Bldg.

R

Rasmussen, Ruth F.
122 N. Lafayette Blvd.
Reese, Lawrence W.
704 N. Main St.
Rigley, E. L. . . . 408 Sherland Bldg.
Rodin, H. H. . . . 422 Sherland Bldg.
Rosenheimer, G. M. . . 604 N. Main
Rubens, Eli 408 Odd Fellows Bldg.
Rudolph, Carl J.
110 West Bartlett St.

S

Sanderson, Robert B.
730 Sherland Bldg.
Sandock, I. . . . 402 Sherland Bldg.
Sandock, Louis F.
428 Sherland Bldg.
Sandoz, Harry H.
615 Odd Fellow Bldg.
Savery, C. E. . . . 230 Sherland Bldg.
Schiller, H. A. 226 Sherland Bldg.
Scott, F. M. 122 N. Lafayette Blvd.
Selby, Keith E. 407 Lincolnway W.
Sellers, Francis M.
1602 E. Wayne
Sennett, C. M. . . . 1129 Belmont
Sensenich, R. L. . . . 203 J.M.S. Bldg.
Sharp, Merle C.
120 N. Lafayette Blvd.
Shelley, Edw. . . . 728 W. Colfax
Skillern, P. G. 1002 Bldg. & Ln. Tr.
Slominski, Harry H.
708 Odd Fellow Bldg.
Spenner, R. W. 726 Sherland Bldg.
Staunton, H. A. 3023½ Mishawaka
Stiver, D. D. . . . 822 Sherland Bldg.
Stogdill, William J.
525 Sherland Bldg.
Stratigos, Joseph S.
713 E. Jefferson Blvd.

T

Thompson, John M.
921 Lincoln Way East
Thompson, Robert A.
530 W. Indiana Ave.
Thornton, M. J. 825 Sherland Bldg.
Traver, P. C. . . . 1010 Riverside Dr.

V-W

Vagner, S. Bernard
1303½ W. Washington
Vurpillat, Francis J.
132 N. Lafayette Blvd.

ST. JOSEPH COUNTY

(South Bend—Continued)

Wegner, W. G. (S) . . . 616 W. Wash.
Weiss, Eugene . . . 2521 S. Michigan
Wilhelm, A. M. 628 Sherland Bldg.
Wilson, James . . . 409 J.M.S. Bldg.
Zeiger, Irvin . . . 3201 Mishawaka

Glick, Julius Walkerton
Nassef, George J. Walkerton
Cline, Kenneth L. Wyatt
Burket, Cecil R.
R. R. 4, Box 514, Norfolk, Va.
Firestein, Ray
Cook Co. Hospital, Chicago, Ill.

SCOTT COUNTY

Bogardus, Carl R. Austin
Hill, Thomas N. Scottsburg
McClain, Marvin L. Scottsburg
Napper, Floyd S. Scottsburg

SHELBY COUNTY

Nigh, Rufus M. Fairland
Davis, John A. Flat Rock
Nave, H. E. Fountaintown
Jean, Thomas A. Morristown
Miller, Frank H. Morristown
Patten, Vernon C. (S) . . . Morristown

Shelbyville

Barnum, Emerson
110 E. Hendricks
Billman, Gustus S. R. 2
Dalton, Wilson L.

301 Methodist Bldg.
Gehres, Robert W. 15 S. Tompkins
Inlow, H. H. . . . 103 W. Washington
Inlow, W. D. . . . 103 W. Washington
Miller, Richard C. . . . 17 Mechanic
Richard, N. F. 103 W. Washington
Scott, V. B. . . . 103 W. Washington
Silbert, David B. 17 S. Tompkins
Spindler, Robt. D. 165 W. Mechanic
Tindall, Paul R. . . . 20 N. Pike
Tindall, W. R. . . . 505 S. Harrison
Whitcomb, Roger F.
302 Methodist Bldg.

Coulson, Sewell B. (S) . . . Waldron
Keeling, James E. (S) . . . Waldron

SPENCER COUNTY

Barrow, John H. Dale
Medcalf, Norman L. Lamar
Atchison, Kenneth C. Rockport
Buxton, Eva J. (S) Rockport
Ehrman, C. D. Rockport
Glackman, John C., Jr. Rockport
Kerrigan, William F. Rockport
Lang, Shirley C. Rockport

STARKE COUNTY

Leinbach, Earl Hamlet
DeNaut, James F. Knox
Henry, Howard S. Knox
Ingwell, Guy B. Knox
McClure, Clark Knox
Farabee, Charles R. North Judson
Grant, Albert J. North Judson
Matthew, J. R. North Judson

STEUBEN COUNTY

Barton, Robert Angola
Cameron, Mary H. Angola
Creel, Donald W. Angola
Crum, Marion M. Angola
Hartman, John J. Angola
Kissinger, Knight L. Angola
Lane, William H. (S) Angola
Mason, Donald G. Angola
Rausch, Norman W. Angola
Blosser, Blaine A. Fremont
Hippensteele, Ralph O. Fremont
Alford, James Hamilton
Denman, Robert D. (S) Helmer

SULLIVAN COUNTY

Brown, John S. Carlisle
Whipps, Charles E. Carlisle
Dukes, Betty Dugger
Dukes, Frederic M. Dugger
Dukes, Joe E. Dugger
Betha, Robert O. Farmersburg
O'Dell, Harry C. Farmersburg
Oliphant, Jacob T. Farmersburg
Hamilton, Antha Ann. Shelbyburn
Bedwell, Marion H. Sullivan
Crowder, James H., Jr. Sullivan
Higbee, Paul Sullivan
Maple, James B. Sullivan
Parmenter, Harry Sullivan
Scott, Garland D. Sullivan
Scott, Irvin H. Sullivan

SWITZERLAND COUNTY

(See Jefferson-Switzerland)

TIPPECANOE COUNTY**Lafayette**

Ade, C. H. 2211 South St.
Ade, Mary K. 2211 South St.
Arnett, Arett C. 312 N. Eighth
Balkema, C. M.
623 Lafayette Life Bldg.
Bauer, Arthur J. . . . 112 N. Seventh
Bayley, William E. Home Hospital
Beeler, James M.

Wabash Valley Sanitarium
Buhrmester, Harry C., Jr.

312 N. Eighth
Burbke, John C. . . . 133 N. Fourth
Calvert, Raymond R. . . 314 N. Sixth
Cole, Ira 2315 South
Cox, Wayne T. 206-7 Schultz Bldg.
Coyner, Alfred B.

509 Lafayette Life Bldg.
Crockett, Franklin S.

312 Lafayette Life Bldg.
Dewey, G. W. (S) . . 122 S. 28th St.
Donahue, George R.

718 Lafayette Life Bldg.
Dubois, Ramon B. . . 2211 South St.
Eaton, M. J.

214 Lafayette Life Bldg.
Engeler, James E. . . 308 N. Eighth
Ferguson, Wm. B. . . 2211 South St.
Flack, Russell A. . . . 217 N. Sixth
Frasch, M. G. Lafayette Life Bldg.
Frey, Harley B.

405 Lafayette Life Bldg.
Gery, Richard E. . . . 312 N. Eighth
Gripe, R. P. 312 N. 8th St.
Harden, Murray

716 Lafayette Life Bldg.

TIPPECANOE COUNTY

(Lafayette—Continued)

Harshman, M. L. . . . 312 N. Eighth
Harter, Eli Blair . . . 312 N. Eighth
Herrold, George W.

2323 South St.
Holladay, Lloyd J.

411 Lafayette Life Bldg.
Hughes, Richard . . . 2216 South St.
Hunsberger, W. G. . . 506 S. 7th St.
Hunter, F. P. Lafayette Life Bldg.
Ikens, Ray G. 605 S. Seventh
Johnson, Herbert S. . . 312 N. 8th St.
Johnson, Lowell R. . . . 2315 South
Jones, David . . . 24 N. Twenty-fourth
Karberg, R. J. . . . 420 Columbia St.
Klatch, Ben Z. . . . 2211 South St.
Klepinger, Harry E.

824 Lafayette Life Bldg.
Laws, H. J.

501 Lafayette Life Bldg.
Laws, Kenneth F.

501 Lafayette Life Bldg.
Levering, Guy P. (S)

819 Central St.
Loop, Floyd A. (S)

2211 South St.
Loop, F. A.

601 Lafayette Life Bldg.
McAdams, H. B. . . . 1411 Sunset Dr.

McAdams, Robert . . . 631 Columbia
McClelland, D. C. . . . 312 N. Eighth

McFadden, James M.
St. Elizabeth Hosp.

McKinley, Joseph
312 Lafayette Life Bldg.

McKinney, Daniel H.
814 Lafayette Life Bldg.

Marsh, G. W. . . . 1405 N. Fourteenth
Marsh, William L.

St. Elizabeth Hosp.
Miller, Roland E. . . . 1625 Kossuth

Morrison, John S. (S)
422 N. 7th St.

Neumann, Kenneth O.
613 Lafayette Life Bldg.

Pearlman, Samuel S. (S)
107 N. Sixth

Peterson, Joel A.
609 Lafayette Life Bldg.

Peyton, Frank W. . . . 15 N. 25th
Ratcliff, Frank W. . . . 300 Main

Rogers, Joseph G. . . . 20 N. 24th St.
Rothrock, Philip W. . . 1625 Kossuth

Ruschli, Edward B.
510 Lafayette Life Bldg.

Shafer, John W. (S) . . 619 Kossuth
Sholty, William M.

405 Lafayette Life Bldg.
Smith, Lowell C. 405 Schultz Bldg.

Stahl, Edward T. . . . 312 N. Eighth
Strayer, Joseph W.

612 Lafayette Life Bldg.
Strickland, Martha B.

2211 South St.
Thomas, Gordon A. . . 608 Columbia

Trout, Carl J. 314 N. Sixth
Tubbs, George R. (S)

608 Columbia
VanBuskirk, E. L. . . . 308 N. Eighth

Vermilya, Robert W.
405 Lafayette Life Bldg.

Washburn, Will W. . . 312 N. Eighth

Mitchell, Edgar T. Romney
Babb, Forrest J. Stockwell

TIPPECANOE COUNTY

(Continued)

West Lafayette

Ash, Harold H. 200 South St.
 Carroll, Bertha Rose
 Purdue University
 Martin, Harold G. 615 Meridian
 Meikle, Louise J. 606 Terry Lane
 Miller, Sayers J. Purdue Univ.
 Romberger, Floyd T. 424 Littleton
 Rommel, C. H. 460 Northwestern
 Schmiedicke, Paul H. 325 Vine St.
 Spurlock, Fae H. 214 Northwestern

Greist, Oliver E.
 1722 N.E. 8th St., Ft. Lauderdale,
 Fla.

TIPTON COUNTY

Stouder, Albert E. Kempton
 Tranter, William F. Sharpsville
 Burkhardt, Boyd A. Tipton
 Carter, Jean V. Tipton
 Compton, George Tipton
 Gossard, Meredith B. Tipton
 Kurtz, William A. Tipton
 Warne, George H. Tipton
 Ericson, Harold L. Windfall
 Moser, Elmer B. (S) Windfall

UNION COUNTY

(See Wayne-Union)

VANDERBURGH COUNTY

Evansville

A

Acre, Robert R. 617 Hulman Bldg.
 Adler, Raymond N. 714 Second
 Alexander, John E.
 609 Hulman Bldg.
 Anderson, Dwight W. 814 N. Main
 Antes, Earl H. 420 Cherry St.
 Austin, E. W. 216 SE Riverside Dr.

B

Baker, H. M. 402 Hulman Bldg.
 Baker, Jas. S. (S)
 2670 Stringtown Road
 Baker, Mason R. 957 S. Ky. Ave.
 Ballas, William A.
 Deaconess Hospital
 Barclay, Irvin C. 114 SE Second
 Barnhart, Willard T. 527 Sycamore
 Baylor, Edward M. 415 S. Lincoln
 Beck, Robert E. 600 Mary St.
 Begley, Joseph W. Jr.
 314 S.E. Riverside Drive
 Bennett, Abner
 Welborn Baptist Hospital
 Bissonnette, Roger P.
 420 Cherry St.

Boswell, R. W. C. 2509 Wash.
 Boyd, Stella N. 502 Hulman Bldg.
 Brockmole, A. W. 517 Edgar St.
 Brown, J. A., Jr. 605 E. Sixth
 Brown, Robert L. 629½ Main St.
 Bryan, S. L. 607 Hulman Bldg.
 Buchholz, R. R. 420 Cherry St.
 Buehner, Donald F.
 2104 Washington Ave.
 Buikstra, C. R. 609 Hulman Bldg.
 Burnikel, Ray H. 527 Sycamore St.

C

Cacia, John J. 609 Hulman Bldg.
 Caldwell, W. C. 504 Old Nat. Bk.
 Cheydleur, Eleanor
 314 S.E. Riverside Dr.
 Clements, Albert F. 15 SE Second
 Clouse, Paul A.
 613 S. Weinbach Ave.
 Cockrum, W. M. 908 Hulman Bldg.
 Cody, Burtis L. 204 Boehne Bldg.
 Coleman, Joseph E.
 216 SE Riverside Dr.
 Combs, H. T. 807 W. Indiana
 Combs, Jno. H. 412 SE Fourth
 Combs, Pearl B. 1623 Lincoln
 Corcoran, P. J. V. 118 S. First
 Crawford, Jas. H. 221 Chestnut
 Crevello, Albert J.
 Clearview Hosp., Kratzville Rd.
 Crimm, Paul D. Boehne Hosp.
 Cullnane, C. W. 2312 W. Franklin

D

Daves, William L.
 608 Old Nat. Bk. Bldg.
 Deems, Myers B.
 314 SE Riverside Dr.
 Denzer, Edw. K. 108 SE Second
 Denzer, Wm. O. 108 SE Second
 Dieckman, H. S. 1012 Cit. Bk. Bldg.
 Diefendorf, Charles F. (S)
 2106B W. Franklin
 Dodd, Roberts K.
 Rt. 6, New Green River Rd.
 Durkee, Melvin S.
 403 Citizens Nat. Bk. Bldg.
 Dycus, Walter A.
 319 N. St. Joseph Ave.
 Dyer, W. K. 221 Chestnut St.

E

Ehrich, William S.
 Evansville State Hosp.
 Eisterhold, J. A. 314 SE Riverside
 Engel, Edgar L. 126 SE Seventh

F

Faul, Henry J. 815 Hulman Bldg.
 Fenneman, Robert J.
 609 Hulman Bldg.
 Fickas, Dallas 619 Mary St.
 Fisher, Wm. C. 413 First Ave.
 Fitz Gerald, Maurice D.
 St. Mary's Hospital
 Fitzsimmons, E. L. 527 Sycamore
 French, Wm. G. Sta. D, Box 2006
 Fritsch, Louis E. 1201 First

G

Garland, Edgar A. 606 S. Weinbach
 Gaul, L. Edw. 509 Hulman Bldg.
 Getty, William H. 420 Cherry St.
 Gill, Bernard P.
 1307 Stringtown Rd.
 Grant, John H. 1401 E. Illinois
 Griep, Arthur H. 420 Cherry St.

H

Hammond, R. Case
 527 Sycamore St.
 Hare, Daniel M. 617 Hulman Bldg.
 Hart, L. Paul. 1436 Lincoln Ave.
 Hartley, C. A., Jr. 221 Chestnut
 Hartz, F. Minton 123 SE Second

Heard, Albert 322 E. Cherry
 Hefti, Karl R. 125 SE Second
 Heinrich, Weston A.
 314 S.E. Riverside Drive
 Henderson, Eugene L.
 118 S.E. First St.
 Hermayer, Stephen
 124 S.E. First St.
 Herrman, Gordon T.
 402 Hulman Bldg.
 Herzer, Clarence C. 322 N. Fulton
 Hobbs, Arthur 600 Mary St.
 Hoopes, Jane M. 125 SE Second
 Huggins, Victor S.
 601 Citizens Nat. Bk. Bldg.
 Hyatt, Gilbert T. 420 Cherry St.

J

Johnson, G. C. (S)
 212 Indiana Bank Bldg.
 Johnson, Stephen L. 521 Sycamore

K

Kauffman, Harley M. 219 Walnut
 Kessler, Robt. B. 1338 Division St.
 Kleindorfer, R. L. 819 W. Franklin

L

Laubscher, Clarence Kratzville Rd.
 Lawrence, Jos. C. 413 First Ave.
 Leich, Chas. F. 124 SE First
 Logan, Jesse R. 503 First Ave.
 Lynch, Harold D. 216 SE Riverside

M

McCool, Joe H. 314 SE Riverside
 McCool, William E. (S)
 R. R. 12, Camp Ground Rd.
 McDonald, Joseph D.
 4300 Lincoln Ave.

Macer, C. G. 901 Hulman Bldg.
 MacKenzie, Pierce 126 SE Seventh
 Mahaffy, John H.

Vanderburgh Child Guidance Ctr.
 Mason, E. E. 906 Hulman Bldg.
 Mehl, Rudolph A. 752 S. Eighth
 Meyer, Keith T. 118 SE First
 Miller, Laverne B. 714 N. Main
 Miller, Milton 15 W. Franklin
 Miller, Minor 201 S.E. Third St.
 Miller, Robert J. 1905 Division
 Mills, Fred E. Deaconess Hosp.
 Mino, Raymond W. 723 Mary St.
 Mino, Robert A. 723 Mary St.
 Moehlenkamp, Charles E.
 614 N. Governor

Muelchi, A. F. 518 Hulman Bldg.
 Murphy, Edw. U.
 908 Hulman Bldg.

N

Nenneker, Henry (S)
 Harmonyway
 Newman, A. E. 912 Hulman Bldg.
 Niedermayer, Alfred J.
 960 Washington Ave.
 Nisenbaum, Harold
 704 Hulman Bldg.
 Nonte, Leo R. 1651-B Lincoln Ave.

O

Olsen, Robert G. St. Mary's Hosp.
 Oppenheimer, Ernst 103 SE Second
 Oswald, Robert
 840 Bayard Park Dr.

VANDEBURGH COUNTY (Evansville—Continued)

P

Pastor, Julius W. . . . 713 First Ave.
Pollard, Walter S. . . 115 SE Second
Porro, Francis W. . . St. Marys Hosp.
Present, Julian . . . 113 S.E. Second
Price, Shirley G. . . . 420 Cherry St.
Pugh, Willis 413 First

R

Raphael, I. J. . . . 617 Hulman Bldg.
Ratliffe, A. W. . . . 510 SE First
Raydin, B. D. . . . 712 Hulman Bldg.
Reich, Clarence E. . . 1209 N. Fulton
Reitz, Thos. F. . . . 700 N. Sixth
Ringham, Jarrett . . . 401 Chandler Ave.
Rininger, H. C. . . . 1359 Washington
Ritz, Albert S. . . . 2605 Lincoln
Robinson, Earle U. . 615 Bellemeade
Rosenblatt, B. B. . 709 Hulman Bldg.
Rossow, Russell . . . 118 SE First
Royster, G. M. . . . 810 Cit. Bk. Bldg.
Royster, R. A. . . . 810 Cit. Bk. Bldg.
Ruddick, H. C. . . . 816 Hulman Bldg.
Rusche, Henry J. . . . 313 W. Iowa
Russell, Richard H. . . St. Mary's Hospital

S

Schaefer, William C. . . St. Mary's Hospital
Schirmer, R. H. . . 1118 W. Franklin
Schneider, Charles P. . 2211 W. Franklin St.
Schriefer, Victor V. . . 1120 N. Main St.
Slaughter, H. C. . . 908 Hulman Bldg.
Slaughter, John . . 101 S.E. Third St.
Slaughter, O. L. . . . 118 E. First
Snively, W. D., Jr. . . . Mead Johnson & Co.
Springstun, Walter R. . 601 Hulman Bldg.
Steckler, Robert J. . . 808 S. Norman Ave.
Steele, Paul W. . . . 1651-B Lincoln Ave.
Sterne, John 221 Chestnut St.
Stork, Urban 412 SE Fourth
Strueh, Paul E. . . . 124 S. First St.
Sutter, Chas. C. . . . Evansville State Hosp.

T

Tager, Stephen . . . 219 Walnut St.
Tilden, Margaret . . . R. R. 13, Box 373-A
Tweedall, D. C. . . . 527 Sycamore St.
Tweedall, D. G. . . . 2114 W. Franklin

U-V

Viehe, Robt. W. . . . 207 SE First
Visher, John W. . . . 805 Old Nat. Bk. Bldg.

W

Watson, James L. . . . 1158 Lincoln Ave.
Weber, Edgar H. . . . 123 SE Second
Weiss, Henry G. (S) . . 614 Hulman Bldg.
Welborn, Mell B. . . . 420 Cherry St.

Wilhelmus, C. Kenneth . . 115 SE 7th St.

Wilhelmus, Gilbert . . . 1028 Wash.
Wilhelmus, Wm. M. . . . R. R. 7
Willis, Chas. F. . . . 1100 S. Bedford
Willison, G. W. . . . 118 SE First
Wilson, J. D. . . . 517 Sycamore St.
Wilson, Ralph 517 Mary
Wishart, Shelby W. . . . 416 3rd & Main Bldg.
Woods, Wm. P. (S) . . . 5050 Lincoln Ave.
Wynn, J. F. . . . 906 Hulman Bldg.

X-Y-Z

Yeck, Charles W. . . . 115 SE Sixth
Young, C. Curtis . . 126 SE Seventh
Zeps, E. Frances . . 2516 Adams St.
Zimmerman, Harold . . 6 SE Second
Zwickel, Ralph E. . . . 417 Third & Main Bldg.

Friedman, Leo . . . 1440 Beacon St., No. 614,
Brookline, Mass.
Kiechle, Frederick L. . . 904 W. Bay View Dr.,
Biloxi, Miss.
King, Everett A. . . . Div. Comm. Officers, U.S.P.H.S.,
Washington, D. C.
Ritchie, William D. . . 607 Wright Ave., Schertz, Tex.
Wyatt, Fred H. . . . 901 Sherman St.
Denver, Colo.

VERMILLION COUNTY

(See Parke-Vermillion)

VIGO COUNTY

Loving, Jury B. . . . New Goshen
DuPuy, Charles M. (S) . . . Riley
McIntosh, Wilbert Riley
Carmichael, Clyde S. (S) . Seelyville

Terre Haute**A**

Agee, Ernest B., Jr. . . 221 S. Sixth
Alexander, Oliver O. . . 301 Rose Disp. Bldg.
Allen, O. T. . . . 422 Rose Disp. Bldg.
Anderson, W. C. . . . 2235 Wabash
Arbonies, William G. . . 2150 N. 31st St.
Asbury, W. D. (S) . . . 322 Rose Disp. Bldg.
Ault, Roy Tribune Bldg.

B

Baldrige, William O. . . 12 Points State Bk. Bldg.
Bannon, William G. . . 416 Rose Dispensary Bldg.
Belshaw, George . . 221 S. Sixth St.
Blum, Leon L. . . . 210 Rose Dispensary Bldg.
Bopp, Henry, Jr. . . 221 S. Sixth St.
Bopp, Henry W. . . 132 Barton Ave.
Bopp, James 2635 Wilson

Bradley, Stephen C. . 916 S. 25th St.
Bronson, Paul J. . . . 721 Wabash
Brown, Robert R. . . . 221 S. Sixth

C

Cajacob, Melville E. . 1000 S. Sixth
Caldwell, Milton V. . . Tribune Bldg.
Carpenter, George C. . . 410 Ohio
Cavins, Alexander W. . 221 S. Sixth
Combs, Chas. N. . . . 2516 N. Ninth
Combs, S. R. . . . 505 Tribune Bldg.
Congleton, George C. . . 308 Merchants Nat. Bk. Bldg.
Conklin, J. O. . . 500 Rose Disp. Bldg.
Curry, C. A. . . 506 Rose Disp. Bldg.

D

Davis, Merle J. . . . 221 S. Sixth St.
Decker, Harvey B. . . 14 Rea Bldg.
Dyer, Geo. W. . . 208 Rose Disp. Bldg.

E

Eisenlohr, Eugen . . . 128 S. Sixth

F

Forsyth, David H. (S) . . 714 S. 8th St.
Freed, J. E. . . 414 Rose Disp. Bldg.
Freed, John E., Jr. . . . 414 Rose Disp. Bldg.
Fuqua, Harold B. . . 1616 N. 9th St.

G

Gerrish, D. A. . . . Rose Disp. Bldg.
Gilbert, Ivan . . 505 Rose Disp. Bldg.
Gillum, John R. (S) . . 221 S. Sixth
Goodman, Hubert T. . . 310 Opera House Bldg.
Gossom, Donn R. . . Rose Disp. Bldg.

H

Harkness, Robert G. . . 301 Rose Disp. Bldg.
Harris, Howard H. . . 112 N. 7th St.
Haslem, E. R. . . 401 Rose Disp. Bldg.
Haslem, John R. . . . 221 S. Sixth
Hoover, Dewey A. . . 14½ N. Third
Humphrey, Paul E. . . . 322 Rose Disp. Bldg.
Hunt, Edgar J. R. R. 1

K

Kabel, Robert N. . . 505 Tribune Bldg.
Kriebble, William W. . . 221 S. Sixth
Kunkler, Joseph . . . 408 Chestnut
Kunkler, William C. . . 212 Merchants Bk. Bldg.

L

LaBier, Clarence Rollin (S) . 1630 Wabash Ave.
LaBier, C. R. . . 1630 Wabash Ave.
Lancet, Robert O. . . . 2022 Wabash
Loewenstein, W. L. . 1537 S. 7th St.
Lockett, C. L. . . 211 Fairbanks Bldg.

M

McBride, Noel S. . . . 407 Merchants Nat. Bk. Bldg.
McCormick, Wilbur C. . . 312 Merchants Bk. Bldg.
McCrea, Fred R. . . 416 Tribune Bldg.
McEwen, James W. . . . 321 Rose Disp. Bldg.
McLaughlin, Gordon C. . . 501 Tribune Bldg.

VANDERBURGH COUNTY

(Terre Haute—Continued)

Mahoney, Charles L. . . . 221 S. Sixth
Malone, Leander A. . . . 721 Wabash
Mason, Lester M. . . .
312 Merchants Nat. Bk. Bldg.
Mattox, Don M. 721 Wabash
Meyn, Werner P. 221 S. Sixth
Miklozek, John E. . . 1461 S. Seventh
Miller, Daniel B. (S) . . 1603 S. 7th
Milleson, Ann L. M. 826 S. 6½ St.
Musselman, G. G. 424 Fourth Ave.

N-O

Nay, Ernest O. 221 S. Sixth
Neudorff, Louis G. 221 S. Sixth St.
Oliphant, R. W. 410 Tribune Bldg.

P

Pearce, Roy V. . . . 1440 S. 25th St.
Pierce, Harold J. 627 Cherry

R

Reed, Robert C. 211 Fairbanks Bld.
Reynolds, Richard J. . . 901 S. 25th
Richart, J. V. 414 Rose Disp. Bldg.
Riggs, Floyd C. 2228 Wabash Ave.
Rubin, Milton M. . . . Tribune Bldg.

S

Sayers, F. E. . . . R.R. 5, Box 39A
Scherb, Burton E. . . 104 N. Seventh
Schott, Edward J. (S) . .
Merchants Nat. Bk. Bldg.
Schumaker, Robert A. . .
211 Fairbanks Bldg.
Selsam, Etta
203 Merchants Nat. Bk. Bldg.
Shanklin, Vernon A. . .
202 Fairbanks Bldg.
Shapiro, Burton J. . . 924 N. 19th St.
Showalter, J. R. . . . 1255½ Maple Rd.
Siebenmorgen, L. . . 1200 S. Eighth
Siebenmorgen, P. . . 1200 S. Eighth
Silverman, N. M. . . 1634 S. Seventh
Sloss, Imit H. . . . 1029 S. Seventh
Smoots, S. A. . . . 1307 Maple Ave.
Solomon, Robert D. . .
Rose Disp. Bldg.

Speas, R. C. 402 Tribune Bldg.
Spigler, James F. . . .
1402 Wabash Ave.

Stewart, Walter E. . . . 721 Wabash
Stoelting, J. L. 507 Rose Disp. Bldg.
Strecker, Wm. L. . . 100 S. 25th St.
Strong, Daniel S. (S) . .
R. R. 7, Box 170

Sullivan, John M. . . .
2242 College Ave.

T

Topping, M. C. . . 505 Tribune Bldg.

U-V

Utterback, Arnold . . .
R. R. 2, West Terre Haute
VanArsdall, C. R. . . . 17 S. Ninth
Voges, Edward C. . . . 1402 Wabash

W

Weber, Joseph G. S. . . 721 Wabash
Weinstein, Joseph H. (S) . .
105 S. 26th St.
White, Jas. V. Tribune Bldg.

VANDERBURGH COUNTY

(Terre Haute—Continued)

Wiedemann, Frank E. (S) . .
222 Rose Disp. Bldg.
Wilson, Fred L. 1501 S. Third
Wyeth, Chas. (S) 1100 S. 7th

X-Y-Z

Zwerner, Paul F. . . .
12 Points State Bk. Bldg.

Day, Theodore P. . . .
34329 Lakeshore Blvd.
Willoughby, Ohio

Johnson, Paul D., Jr. . .
223 3rd & Altizer Sts.,
Huntington, W. Va.

Wilkerson, Edward L. . .
17th Army Eng. Bn.,
A.P.O. 42, New York, N. Y.

WABASH COUNTY

McKay, Robert D. . . . LaFontaine
Walker, James L. . . . LaFontaine
Balsbaugh, Geo. . . N. Manchester
Brubaker, O. G. (S) . .
N. Manchester
Bunker, L. Z. N. Manchester
Cook, Chas. E. N. Manchester
Seward, Geo. W. N. Manchester
Venable, Geo. L. . . . N. Manchester
Warvel, Joseph L. (S) . .
N. Manchester

Kidd, James G. Roann
Black, Edgar K. Wabash
Dannacher, Wm. D. . . . Wabash
Elward, Carl J. Wabash
Jewett, Robert E. . . . Wabash
LaSalle, Robert M. . . . Wabash
Matteucci, Walter V. . . Wabash
Mills, John F. Wabash
Pearson, William E. . . . Wabash
Rhamy, Arthur P. Wabash
Steffen, Arthur J. . . . Wabash
Steffen, Julius T. . . . Wabash
Stoops, Jean T. Wabash
Wall, Joseph A. Wabash
Whisler, Frederick M. . . Wabash
Jewett, Laurence (S) . .
407 Concourse,
Excelsior Springs, Mo.

Thompson, Noah H. (S) . .
Elks Home, Bedford, Va.

WARREN COUNTY

(See Fountain-Warren)

WARRICK COUNTY

Dimmett, Robert Boonville
Hoover, Peter B. Boonville
Purcell, Jack H. Boonville
Samples, John T. (S) . . Boonville
Stover, Wendell C. . . . Boonville
Wilson, Paul E. Boonville
Taylor, Lon S. Elberfeld
Faith, Ira L. Newburgh
Wilhelmus, Charles M. . Newburgh

WASHINGTON COUNTY

Tower, Thomas K. . . Campbellsburg
Green, William L. (S) . . . Pekin
Apple, Eddie Salem
Episcopo, A. R. Salem
Gilliatt, James P. Salem
Huckleberry, Irvin E. . . Salem
Mull, Philip L. (S) . . .
Bluegrass Hotel, Louisville, Ky.

**WAYNE-UNION
COUNTIES**

Clark, Marion E. . . Cambridge City
Hill, Paul G. Cambridge City
Kenyon, Charles E. Cambridge City
Barton, Willoughby M. Centerville
Hutchison, Donald R. Fountain City
Zimmerman, Wm. H. . . . Dublin
Marsh, Chester A. . . . Hagerstown
Miller, William A. . . . Hagerstown
Newnum, Raymond L. Hagerstown
Dubois, Franklin T. (S) . . Liberty
Lewis, James F. Liberty
McWilliams, William B. . . Liberty
Thompson, Will A. (S) . . Liberty
Denny, Edgar C. Milton

Richmond

Adney, Frank B. . . .
306 Medical Arts Bldg.

Ake, Loren
410 First Nat. Bk. Bldg.

Allen, Hubert E. . . . 21 S. Eighth
Allen, Robert T. . . . 21 S. Eighth
Ballenger, William E. . .
309 Med. Arts Bldg.

Blossom, Paul W. . . . 825 S. A St.
Bond, Charles S. (S) . . 112 N. 10th
Buche, Fredk. P. . . . 106 S. Seventh
Campbell, Perry A. . .
422 Med. Arts Bldg.

Coble, Frank H. . . . 51 S. Eighth
Cook, Norman R. . . .
428 Medical Arts Bldg.

Cox, Leon T. 36 S. Eighth
Daggy, James R. . . . 35 S. 8th St.
Dingle, P. E. . . . 403 Med. Arts Bldg.
Ebbinghouse, Tom . . . 98 W. Main
Ewbank, J. Nelson . . .
Smith-Esteb Hosp.

Griffis, V. C. . . . 208 Med. Arts Bldg.
Harmon, C. J. 407 Med. Arts Bldg.
Harmon, G. H. 407 Med. Arts Bldg.
Hays, George R. . . .
401 Second Nat. Bk. Bldg.

Herring, George N. . .
Richmond State Hospital
Hill, H. D. . . . 412 Med. Arts Bldg.
Hunt, G. J. . . . Reid Memorial Hosp.
Johnson, George M. . .
403 Medical Arts Bldg.

Johnson, P. S. 215 Med. Arts Bldg.
Kime, Charles E. . . . 810 S. A St.
Krueger, Fredk. W. . . 45 S. Seventh
Laird, Leslie A. . . . Rich. St. Hosp.
Lee, G. W. . . . 139 Med. Arts Bldg.
Ling, John F. 130 Med. Arts Bldg.
Logan, James Z. . . .
303 Second Nat. Bk. Bldg.

Loomis, Charles H. . .
Medical Arts Bldg.

Mader, John H. . . . 808 South A
Malcolm, R. . . . 127 Med. Arts Bldg.
Meredith, Elwood J. . .
203 Med. Arts Bldg.

Park, Byron J. . . . 300 S.W. 5th
Ramsdell, Glen A. . . 1020 Peacock
Ross, Harry P. . . .
410 Second Nat. Bk. Bldg.

Ross, James S. . . . 321 S. 14th St.
Runge, Paul W. . . . 1426 E. Main
Sage, Charles V. . . . 47 S. Eleventh
Shields Tom S. . . . 47 S. Eleventh
Snyder, M. C. 130 Med. Arts Bldg.
Stamper, L. A. 402 Med. Arts Bldg.
Stepleton, J. D. . . Reid Mem. Hosp.

WAYNE-UNION COUNTIES

(Richmond—Continued)

Stillwell, William R.
21½ S. 8th St.
Sweet, H. E. 35 S. 8th St.
Taylor, W. R. . . . 308 Med. Arts Bldg.
Vance, W. C. . . . 136 Med. Arts Bldg.
Wanninger, Horace
408 Second Nat. Bk. Bldg.
Warrick, Francis B. . 1426 E. Main
Weinstein, E. B. . 204 Colonial Bldg.
Wertenberger, Morris D.
Reid Mem. Hosp.
Whallon, Arthur J. . . 29 S. Tenth
Williams, Paul D. . . Rich. St. Hosp.
Wisener, G. H. . 213 Med. Arts Bldg.
Yencer, Martin W. (S) . 22 N. 14th

Heck, Rolfe A. . . College Corner, O.
Shepard, Fred F.
College Corner, Ohio
Faulkner, W. H.
Meharry Med. Col.,
Nashville, Tenn.

WELLS COUNTY

Bluffton

Annis, Homer B. 303 S. Main
Aucreman, Charles J. . . 303 S. Main
Brickley, Harry D. . . . 227 S. Main

Brickley, Richard A. . . 227 S. Main
Buckner, Joy F. . 116 E. Walnut St.
Caylor, Harold D. . . . 303 S. Main
Caylor, T. E. 303 S. Main
Cook, Robert G. 303 S. Main
DeVoe, Kenneth . . . 725 S. Oak St.
Dorrance, Thos. O. . . . 303 S. Main
Eisaman, Jack L. 303 S. Main
Gillette, Walter R. . 303 S. Main St.
Gitlin, Max M. 121½ E. Market
Gitlin, William A. . . 121 E. Market
Hamilton, O. G. 227 S. Main
Jackson, Charles E. . . 303 S. Main
Johnston, Robert L. . . 303 S. Main
Kephart, S. Bruce . . . 303 S. Main
Mead, Clarence H. . . . 227 S. Main
Mitchell, George S. . 303 S. Main St.
Nickel, Allen 303 S. Main
Shively, John A. . . . 303 S. Main St.
Talbert, Pierre C. . . . 303 S. Main
Tirman, Wallace S. . . . 303 S. Main
Yoder, Richard P. . . . 303 S. Main

Gingerick, C. M. . . . Liberty Center
Davidoff, Manuel A. Ossian
Hardin, Wayne E. Ossian

WHITE COUNTY

Galbreth, Jesse P. (S) Burnettsville
Derhammer, George L. . . Brookston
Gish, Howard M. Brookston
Netherton, Clyde R. . . . Chalmers
Houser, Wayne W. Monon
McClure, Stanley E. Monon
Beck, David C. Monticello
Carney, John C. Monticello
Greist, H. W. (S) Monticello
Hibner, Nolan Monticello
Morris, Warren V. Monticello
Mayfield, Clifford H. (S) . Reynolds
Baynes, Frank L. Wolcott
Forbes, Violet M. Crabbe . Wolcott

WHITLEY COUNTY

Hershey, Ernest A. . . . Churubusco
Minick, Linus Churubusco
Hamilton, Thomas . . . Columbia City
Heritier, Claude J. . . Columbia City
Kratz, Paul E. Columbia City
Langohr, John Columbia City
Lehmberg, Otto F. . . Columbia City
Nolt, Ernest V. Columbia City
Thompson, Frank . . . Columbia City
Tyler, Robert L. . . . Columbia City
Huffman, Verlin P. . . South Whitley

WOMAN'S AUXILIARY
TO THE
INDIANA STATE MEDICAL ASSOCIATION

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VICE-PRESIDENT:	Mrs. William R. Tindall	616 S. Harrison St.	Shelbyville
SECOND			
VICE-PRESIDENT:	Mrs. J. W. Mather	2357 Vigo St.	East Gary
THIRD			
VICE-PRESIDENT:	Mrs. Fielding P. Williams	511 Geiger	Huntingburg
FOURTH			
VICE-PRESIDENT:	Mrs. C. P. McLaughlin	Fall Creek Pkwy.	Pendleton
RECORDING			
SECRETARY:	Mrs. Walter L. Portteus	R. R. 2, Box 11B	Franklin
CORRESPONDING			
SECRETARY:	Mrs. Ted L. Grisell	5411 Broadway	Indianapolis
TREASURER:	Mrs. John M. Sullivan	2242 College Ave.	Terre Haute
PARLIAMENTARIAN:	Mrs. Charles F. Voyles	4150 N. Meridian St.	Indianapolis
HISTORIAN:	Mrs. Philip W. Rothrock	2061 S. 9th St.	Lafayette

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PUBLICITY:	Mrs. Frank Gastineau	5344 N. Pennsylvania St.	Indianapolis
PROGRAM:	Mrs. E. L. Fitzsimmons	500 S. Boeke Rd.	Evansville
RURAL &			
SCHOOL HEALTH:	Mrs. D. E. Lybrook	R. R. 2	Galveston
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AMERICAN MEDICAL			
EDUCATION			
FOUNDATION:	Mrs. Francis M. Fargher	Pottawattomie Park	Michigan City

MEMBERSHIP ROSTER—BY COUNTIES

BY COUNTIES

ADAMS COUNTY

Berne
Beaver, Mrs. N. E. 365 N. Harrison
Habegger, Mrs. M. L. 505 Clark
Lehman, Mrs. Harold B. Franklin
Reusser, Mrs. Amos 256 Sprunger
Decatur
Burk, Mrs. J. M. 221 S. Third
Carroll, Mrs. J. C. R. R. 4
Girod, Mrs. A. H. 1004 W. Monroe
Kohue, Mrs. G. J. 304 W. Adams
Parrish, Mrs. Richard 238 S. Second
Rayl, Mrs. C. C. 334 S. First
Reppert, Mrs. R. L. Road No. 224
Smith, Mrs. W. E. 116 S. Third
Zwick, Mrs. H. F. 401 E. Rugg
Geneva
Schetgen, Mrs. J. V. Box 236

ALLEN COUNTY

Bluffton
Brickley, Mrs. Harry D. 227 S. Main
Buckner, Mrs. J. 116 E. Walnut
Hamilton, Mrs. O. G. 203 E. Central
Mead, Mrs. C. H. 221 W. Washington
Fort Wayne
A
Adams, Mrs. J. R. 2538 Fairfield Vw. Pl.

Aiken Mrs. A. F. 1927 E. State
Aiken, Mrs. N. E. 1923 E. State
Aldrich, Mrs. Harry 2710 Broadway
Arata, Mrs. Justin 4220 Fairfield
B
Bailey, Mrs. Paul 1840 Pemberton
Baltes, Mrs. J. H. 4816 Beaver Ave.
Bash, Mrs. W. E. 4626 Stratford Road
Beams, Mrs. Ralph 1801 California
Beierlein, Mrs. Karl M. Butler Road
Bergendohl, Mrs. Emil 4225 Tacoma
Blosser, Mrs. H. V. 1122 W. Washington
Bolman, Mrs. R. M. Jr. 4135 S. Harrison
Bonner, Mrs. Joseph 310 E. Washington
Borders, Mrs. Theodore 1145 S. Lafayette
Bowers, Mrs. G. T. 2609 East Drive
Bowers, Mrs. J. W. 817 E. Washington Blvd.
Brown, Mrs. Frederic 906 Woodview
Bruggeman, Mrs. H. O. 1202 W. Washington
Bryan, Mrs. Franklin A. 1439 Edgewater

Buckner, Mrs. Doster Bass Road
Buckner, Mrs. George D. 1220 Kensington
Bulson, Mrs. E. L. 4301 Pembroke
C
Calvin, Dr. Jessie C. 312 W. Wayne
Cameron, Mrs. D. F. 2724 N. Clinton
Carlo, Mrs. Ernest 4633 Crestwood
Cartwright, Mrs. E. L. 529 W. Packard
Catlett, Mrs. M. B. 1143 W. Rudisill
Clark, Mrs. Wm. 4002 S. Harrison
Cochran, Mrs. H. A., Jr. 4811 S. Wayne
Cooney, Mrs. Charles 1168 Westover Road
Culp, Mrs. John E. 1216 Illsley Drive
D
Dancer, Mrs. Charles 905 Columbia Ave.
Datzman, Mrs. Richard C. 5402 Bluffton Rd.
Dunstone, Mrs. H. C. 4134 Indiana
E
Eberly, Mrs. Karl C. 1240 W. Rudisill
English, Mrs. C. H. 2509 Webster
Estlick, Mrs. Richard E. 4223 Beaver

(Fort Wayne—Continued)

F
Foy, Mrs. H. W. 1816 Forest Park
G
Gerding, Mrs. Wm. J. 1721 Forest Park
Glock, Mrs. Wayne R. R. 2
Goebel, Mrs. Carl W. 4815 Tacoma
Graham, Mrs. George M. 1126 W. Rudisill
Griest, Mrs. Walter D. 171 Travers Pl.
H
Haffner, Mrs. Herman G. 3606 Mulberry Rd.
Haller, Mrs. Robert 828 Kinnaird
Hamilton, Mrs. Emory D. 2405 Florida Dr.
Harvey, Mrs. Harry 2228 Crescent
Hasewinkle, Mrs. A. M. 3544 Kirkland
Hastings, Mrs. Warren C. 1822 Kensington
Hattendorf, Mrs. A. P. 4041 Old Mill Rd.
Havens, Mrs. Russell E. 1845 Kensington
Hoffman, Mrs. Arthur F. 4223 Indiana
Hoffmann, Mrs. S. P. 234 E. Maple Grove
Holsinger, Mrs. Robert E. 4617 Indiana
Howe, Mrs. F. L. 1031 Kensington
J
Jackson, Mrs. John F. 414 W. Rudisill
Johnson, Mrs. Richard M. 2026 Bayer
Jurgensen, Mrs. Walter 1307 E. Rudisill
K
Kaufman, Mrs. Julian 4726 S. Anthony
Keck, Mrs. Carleton A. 4818 S. Anthony
Kent, Mrs. Richard N. 2717 East Dr.
Kidder, Mrs. O. T. Lima Rd.
Kimbrough, Mrs. Robert 4319 Drury Lane
Kissinger, Mrs. Charles C. Veterans Hospital
Kleifgen, Mrs. W. A. 4005 S. Calhoun
Kruse, Mrs. Edward 4001 Old Mill Rd.
L
Ladig, Mrs. Donald S. 2720 Fairfield
Land, Mrs. Francis L. 1716 Capitol
Lehner, Mrs. John 1119 Maxine
Leming, Mrs. Ben L. 3005 N. Anthony
Lenk, Mrs. George E. State St. Ex. R. R. 9
Lill, Mrs. L. C. 4221 Buell
Lohman, Mrs. Robert M. 2138 Owaissa
Loudermilk, Mrs. J. L. 1723 Pemberton
Lyon, Mrs. Wm. C. 2401 Indian Village
M
McArdle, Mrs. Edward G. 1133 Rudisill Blvd.

McBride, Mrs. W. O. 610 Beechwood Circle
McCallister, Mrs. John W. 4215 Drury Lane
McCoy, Mrs. Roy R. 4101 S. Harrison
McDowell, Mrs. G. A. 2322 Forest Park Blvd.
McEachern, Mrs. Cecil 4705 Indiana
McFall, Mrs. J. S. 3322 Garland
McKeeman, Mrs. D. H. 1615 Ardmore
McNairy, Mrs. Donald J. 4522 Beaver
Mackel, Mrs. F. O. 1610 Nuttman
Manning, Mrs. George 4117 S. Anthony
Mensch, Mrs. James R. 4826 S. Anthony
Mercer, Mrs. S. R. 3235 W. Washington
Meyer, Mrs. T. O. 4438 Wilmette
Michaelis, Mrs. S. C. 1255 Korte Lane
Miller, Mrs. Carl 457 Oakdale Dr.
Miller, Mrs. H. Paul 6408 S. Calhoun
Miller, Mrs. Mahlon 1115 Illsley
Miller, Mrs. Orval J. 1102 Kensington
Miller, Mrs. Richard 1322 W. Foster
Moats, Mrs. Carl 3210 N. Washington
Moats, Mrs. George 2107 Kensington
Moravec, Mrs. Arthur 4711 Old Mill Rd.
Mortenson, Mrs. Leland J. 1310 N. Foster Parkway
Mueller, Mrs. Lawrence 3423 S. Washington Rd.
N-O
Nahrwold, Mrs. E. W. 3314 Irvington
Nill, Mrs. John 440 W. Fleming
O'Rourke, Mrs. Carroll N. Hamilton Rd.
Oyer, Mrs. J. H. 2206 Wawonissa
P
Painter, Mrs. Donald Washington Center Rd.
Parker, Mrs. C. B. 2215 Paulding Rd.
Perrin, Mrs. Kermit Maysville Rd.
Perry, Mrs. Frederic G. 709 Kinnaird
Phillips, Mrs. John 615 Nuttman
Popp, Mrs. Milton F. 3148 Parnell
R
Ranke, Mrs. Henry 3112 Beaver
Ray, Mrs. Herbert 325 E. Creighton
Rhamy, Mrs. B. W. 4312 Beaver
Rissing, Mrs. Walter 3200 Irvington
Rodriguez, Mrs. Juan 4720 Crestwood Dr.
Roser, Mrs. Arthur Leesburg Rd.
Rossiter, Mrs. D. L. 724 Oakdale Dr.
Rothberg, Mrs. Maurice 4801 Tocoma
Rothschild, Mrs. Charles J. 3015 N. Anthony

S
Salon, Mrs. Harry 4017 Hiawatha Blvd.
Salon, Mrs. N. L. Scottswood Ct., R. R. 6
Sarver, Mrs. Francis E. 4629 Tacoma
Savage, Mrs. Robert 1602 Fairhill Rd.
Schlademan, Mrs. K. R. 4029 Weisser Park
Schlegel, Mrs. Edward 2219 N. Anthony Blvd.
Schmidt, Mrs. Eugene E. 103 E. Fleming
Schmoll, Mrs. Robert J. 2129 Owaissa
Schneider, Mrs. Louis A. 1351 W. Sherwood
Scoins, Mrs. W. H. 4301 Taylor
Scott, Mrs. H. Vaughn 5224 Fairfield
Senseny, Mrs. Eugene F. 730 W. Oakdale
Sherwood, Mrs. Clarence Lima Rd., Irene Byron San.
Sherwood, Mrs. J. V. Lima Rd., Irene Byron San.
Shinabery, Mrs. Lawrence 1850 Broadway
Singer, Mrs. Elmer 825 Oakdale Dr.
Smith, Mrs. Phillip L. 3008 S. Lafayette
Snyderman, Mrs. S. C. 29 Willoughby Pl.
Somers, Mrs. G. H. 527 W. Fleming
Stauffer, Mrs. Richard 4120 S. Harrison
Stellner, Mrs. Howard A. 4134 S. Calhoun
Stier, Mrs. Paul 3807 Fairfield
T
Tennant, Mrs. D. 3513 Kirklin
Terrill, Mrs. Richard 4727 Old Mill Rd.
Thornton, Mrs. W. E. 601 Oakdale Dr.
V
Van Buskirk, Mrs. E. W. 920 Maxine Dr.
W
Warfield, Mrs. C. H. 1809 Kensington
Weber, Mrs. John R. 1215 Sheridan Court
Welty, Mrs. S. G. 509 Oakdale Dr.
Wilkins, Mrs. Robert 4839 Old Mill Rd.
Williams, Dr. Bernice 3526 N. Washington Rd.
Wilson, Mrs. Leslie 2810 S. Wayne
Wilson, Mrs. Roland 1431 Hugh
Wright, Mrs. William 1834 Pemberton Dr.
Wyatt, Mrs. J. L. Jr. 3401 N. Washington Rd.
Z
Zehr, Mrs. Noah 301 W. Creighton
Zweig, Mrs. Elmer 3365 Garland
New Haven
Dahling, Mrs. C. W. 1206 Powers
Emenhiser, Mrs. D. C. 1040 Lincoln Highway
Hoetzer, Mrs. E. M. R. R. 2
Smith, Mrs. G. A. Lincoln Highway
Stumpf, Mrs. E. E.

**BARTHOLOMEW-BROWN
COUNTIES****Columbus**

Adler, Mrs. David Leo... 931 Fifth
 Beggs, Mrs. Lowell F. 2733 Riverside Dr.
 Carpenter, Mrs. T. D. 2328 Gilmore
 Davis, Mrs. Marvin R. 2228 Lafayette
 Fisher, Mrs. Walter S. 906 Franklin
 Hart, Mrs. Robert B. 1203 16th
 Hawes, Mrs. Marvin R. 2975 Franklin Dr.
 Henry, Mrs. Alvin L. 1913 Chestnut
 Kincaid, Mrs. J. C. 4 Mile House Rd.
 Macy, Mrs. George 2603 Washington
 Marr, Mrs. Griffith 1513 17th
 Norton, Mrs. H. J. 909 Pearl
 O'Bryan, Mrs. Richard 1602 Washington
 Overshimer, Mrs. Lyman 1715 Franklin
 Reid, Mrs. Robert 2227 Pennsylvania
 Rittenman, Mrs. George W. 2209 Caldwell Dr.
 Rothring, Mrs. Howard E. 2226 Pearl
 Ryan, Mrs. Wm. J. 2244 Pearl
 Schmitt, Mrs. R. K. 2639 Riverside Dr.
 Williams, Mrs. E. W. 1902 Franklin
 Wissman, Mrs. Wm. L. 1930 Lafayette
 Yoder, Mrs. Dewey D. 718 Lafayette
 Zaring, Mrs. Byron K. 2419 Riverside

Dudding, Mrs. Joseph E. Hope
 Smith, Mrs. Don Hope
 Schneider, Mrs. Kenneth Nashville

BENTON COUNTY

Taylor, Mrs. W. H. Ambia
 Atkinson, Mrs. C. W. Boswell
 Leak, Mrs. Robert Boswell
 Coddens, Mrs. A. L. Earl Park
 Turley, Mrs. Verne L. 501 E. 5th St., Fowler
 Scheurich, Mrs. Virgil Oxford
 Smith, Mrs. Charles G. Otterbein

BOONE COUNTY

Schaaf, Mrs. Alvin Jamestown
Lebanon
 Ballard, Mrs. Robert Country Club Park
 Coons, Mrs. John Country Club Park
 Coons, Mrs. Ritchie 1617 Park Dr.
 Headley, Mrs. Lloyd Country Club Park
 Honan, Mrs. Paul Elmwood Addition
 Kern, Mrs. Clarence 423 E. Main
 Rainey, Mrs. E. A. 912 N. Meridian
 Spieth, Mrs. William Country Club Park
 Weddle, Mrs. Charles 1210 N. East

Wiseheart, Mrs. Robert Country Club Park

Bassett, Mrs. Clancy Thorntown
 Gregg, Mrs. Edwin Thorntown
 Lovett, Mrs. Harvey Whitestown
 Bailey, Mrs. Lawrence Zionsville
 Harvey, Mrs. Ralph Zionsville

CARROLL COUNTY

Van Kirk, Mrs. John Burlington
Delphi
 Brown, Mrs. Tom W. North
 Bryne, Mrs. John Franklin
 Crampton, Mrs. Chas. Monroe
 Maggart, Mrs. Ralph R. R. 3
 Wagoner, Mrs. John W. North
 Wagoner, Mrs. Geo. W. W. Summit

Adams, Mrs. Max Flora
 Brookie, Mrs. Roger Flora
 McLaughlin, Mrs. James Flora

CASS COUNTY**Galveston**

Dutchess, Mrs. C. W.
 Lybrook, Mrs. D. E. R. R. 2

Logansport

Adamski, Mrs. M. S. 614 17th
 Bailey, Mrs. Earl W. 2522 North
 Ballard, Mrs. Charles A. R. R. 4
 Bradfield, Mrs. John R. R. 4
 Cooper, Mrs. Thomas L. 2104 North

Crandall, Mrs. W. E. 1330 E. Broadway
 Davis, Mrs. John 2119 North
 Ferguson, Mrs. John T. Longcliff State Hosp.
 Fitzgerald, Mrs. Brice 1930 High
 Gordon, Mrs. Myra 1515 E. Broadway
 Hall, Mrs. Bernard R. 1707 E. Broadway
 Hedde, Mrs. E. L. R. R. 5
 Hillis, Mrs. L. J. 2508 E. Broadway
 Holloway, Mrs. W. A. 200 Eel River

Holmes, Mrs. Will W. R. R. 4
 Jewell, Mrs. E. B. 3019 S. Pennsylvania
 Jones, Mrs. J. Carl R. R. 3
 Maxwell, Mrs. J. B. 1119 High
 Morrical, Mrs. R. J. 920 Michigan
 Morrow, Mrs. G. W. Longcliff State Hospital

Schenck, Mrs. Foss 97 21st St.
 Shultz, Mrs. Harry 412½ Fourth
 Slimp, Mrs. Thomas E. 919 North
 Viney, Mrs. Charles R. R. 4
 Wilson, Mrs. Paul R. R. 5
 Winter, Mrs. Donald K. 2541 E. Broadway

Newcomb, Mrs. W. K. Royal Center
 Flanagan, Mrs. E. P. Walton

CLARK COUNTY**Charlestown**

Goodman, Mrs. Eli 511 High
 Patterson, Mrs. Cecil L. 1415 Tunnel Mill Rd.

Havens, Mrs. Lyle 218 S. Sunset, Clarksville

Willner, Mrs. Alan 117 N. Randolph, Clarksville
 Greene, Mrs. Wm. R. Henryville
Jeffersonville

Adair, Mrs. Sam R. R. 1, Utica Pike
 Buckley, Mrs. E. P. 14 Blanchel Terrace
 Buehler, Mrs. George 705 Meigs Ave.

Carlberg, Mrs. Dale L. 2 Blanchel Terrace
 Carney, Mrs. J. T. 203 Sparks
 Clark, Mrs. Wm. B. Jr. 21 Blanchel Terrace

Dare, Mrs. Lee 215 Sparks
 Forsee, Mrs. Norman 506 E. Charlestown
 Graham, Mrs. Lula B. 713 E. Maple

Havens, Mrs. Thomas 416 W. Riverside
 Huoni, Mrs. John S. 6 Blanchel Terrace

Isler, Mrs. Nathaniel 901 Morningside Dr.
 Weems, Mrs. Mallory P. Hopkins Lane

Witt, Mrs. W. R. 908 E. Spring St., New Albany
Sellersburg
 Sturgis, Mrs. Donald G.

CLAY COUNTY**Brazil**

Maurer, Mrs. J. Frank 6 E. Park
 Maurer, Mrs. Robert M. 1115 N. Meridian
 Palm, Mrs. John M. 27 E. Church
 Sourwine, Mrs. Clint C. 141 N. Walnut

Weaver, Mrs. Timothy M. R. R. 2
 Webster, Mrs. Robert K. 25 N. Beech

Wood, Mrs. Opal L. 428 E. Blaine
Clay City

Bond, Mrs. Walter C. 8th and White
 Glosson, Mrs. Jack R. 316 N. Main

Moon, Mrs. Charles E. Center Point
 Ward, Mrs. H. H. Coalmont

**DAVIESS-MARTIN
COUNTIES**

Rohrer, Mrs. James Elnora
 Chattin, Mrs. Robt. Loogootee
 Lett, Mrs. E. B. Loogootee
 McCracken, Mrs. J. O. Montgomery
 Coleman, Mrs. H. G. Odon
 Sears, Mrs. Don Odon
 Maschmeyer, Mrs. Robt. Shoals

Washington

Blazey, Mrs. A. G. 7 E. Walnut
 Burriss, Mrs. B. O. Pine Court
 Chattin, Mrs. Vance Green Acres
 Farris, Mrs. John 411 William
 Fox, Mrs. Philip Green Acres
 Lindsay, Mrs. H. B. Bedford Rd.
 Lloyd, Mrs. C. A. N. E. 2nd
 McKittrick, Mrs. Jack Green Acres
 McKittrick, Mrs. W. O. Green Acres

McNaughton, Mrs. L. M. 812 E. Main

(Washington—Continued)

Norton, Mrs. Horace... 511 Hefron
Rang, Mrs. Arthur... 211 E. Ninth
Rang, Mrs. Robert... 214 E. Ninth
Schroeder, Mrs. Roland... N. E. 1st
Shields, Mrs. Harry... Bedford Rd.
Smoot, Mrs. Brayton... Troy Rd.
Schafer, Mrs. Wm. C.
221 N. E. 9th

**DEARBORN-OHIO
COUNTIES**

Aurora
Baker, Mrs. Leslie M... 204 Fifth
Olcott, Mrs. Charles W.
422 Sunnyside
Stewart, Mrs. Omer H.
Second and Bridgeway

McNeeley, Mrs. Matthew J.
Dillsboro
Elliott, Mrs. John C... Guilford
Lawrenceburg
Fagely, Mrs. William J.
57 Oakley

Houston, Mrs. Fred D... Miller Ave.
Pfeifer, Mrs. James M... 550 Ludlow
Streck, Mrs. Francis A... Ridge Ave.
Vail, Mrs. George A... Ludlow

Rising Sun
Fessler, Mrs. Gordon
Manley, Mrs. Charles N.

DECATUR COUNTY

Tremain, Mrs. M. A... Adams
Greensburg
Acher, Mrs. Robert P.
446 E. Washington
Blemker, Mrs. Russell
332 E. North

Callaghan, Mrs. W. C.
Lincoln Park R. R. 1
Dickson, Mrs. Dale D.
825 N. Broadway
Miller, Mrs. James C... 178 N. Mich.
McKee, Mrs. Harry S... 190 N. Mich.
Morrison, Mrs. J. Trevor... N. Mich.
Overpeck, Mrs. Charles... R. R. 8
Sallee, Mrs. Wm. T... 245 S. Mich.

**DELAWARE-BLACKFORD
COUNTIES**

Brown, Mrs. Stewart D... Albany
Puterbaugh, Mrs. Karl... Albany
Daleville
Hurley, Mrs. John
Rutledge, Mrs. Jean
Tucker, Mrs. O. A.

Gaston
Downard, Mrs. Leland F.
Montgomery, Mrs. Lall G.
Box 149, ARFD 1

Douglas, Mrs. William Montpelier
Muncie

A
Adams, Mrs. William B.
W. Jackson St. Pike
Alvey, Mrs. Charles R.
3001 Torquay Rd.
Anthony, Mrs. Harvey M.
822 W. Charles

B

Ball, Mrs. Clay A... 1015 Linden
Ball, Mrs. Philip... 921 W. Main
Bibler, Mrs. Henry... Parkway Dr.
Botkin, Mrs. Clyde G.
2904 Riverside Ave.
Botkir, Mrs. Tom... 1007 W. North
Bowles, Mrs. Herman... 324 N. Vine
Bowles, Mrs. John H... 408 Wayne
Brown, Mrs. Karl T... 905 E. Adams
Brown, Mrs. Leland... 2012 W. 9th
Brown, Miss Nellie Gates
Brown, Mrs. Thomas

R. R. 6, Box 171
Burwell, Mrs. Stanley W.
211 N. Calvert
Butterfield, Mrs. Robert
1002 W. Gilbert

C

Chereck, Mrs. Edward
2707 W. North
Clauser, Mrs. Eldo... 1 Briar Rd.
Clevenger, Mrs. Joseph H.
3124 University Ave.
Cole, Mrs. Russell E.
431 W. Howard
Covalt, Mrs. Wendell... 120 Berwyn
Cure, Mrs. Elmer T.
913 University Ave.

D

Davis, Mrs. Ed. C... 45 Warwick Rd.
Deutsch, Mrs. Wm... 2100 Petty Rd.
Dunn, Mrs. Farrell W.
1416 Wheeling Ave.

E-F

Eissman, Mrs. Eugene,
211 Alden Rd.
Funk, Mrs. John
3700 Peachtree Lane

G

Garling, Mrs. L. C... 37 Briar Rd.
Gill, Mrs. Tom... 2600 W. Jackson
Greiber, Mrs. Marvin... 310 Riley Rd.
Gustafson, Mrs. Milton H.
230 Stradling Rd.

H-I

Hall, Mrs. O. A... 3121 W. Gilbert
Harris, Mrs. Edmund J.
409 Carson
Hayes, Mrs. T. R... 920 W. North
Henderson, Mrs. Ramon
75 Warwick Rd.
High, Mrs. Ralph
2825 University Ave.
Hill, Mrs. Frank... 321 Calvert
Hill, Mrs. Howard... 106 Berwyn Rd.
Hill, Mrs. Robert
State Rd. No. 3 South
Hostetter, Mrs. I. S... 300 Winthrop
Hurley, Mrs. Anson
1007 University

Imhof, Mrs. J. D.
307 Granville Ave.

K

Kammer, Mrs. Walter F.
919 W. Main
Kemper, Mrs. Arthur
600 E. Wash.
Kirshman, Mrs. F. E... 41 Briar Rd.
Ko, Mrs. Richard... R. R. 7
Kuder, Mrs. Howard F.
1208 N. Walnut

M

Mason, Mrs. L. R.,
3013 Oaklyn Ave.
McClellan, Mrs. John... 331 E Adams
McClintock, Mrs. James A.
611 Beechwood
McCoy, Mrs. George... 517 S. Talley
Molloy, Mrs. W. J., 619 E. Charles
McDowell, Mrs. Fletcher
500 W. Main
Morris, Mrs. J. W.
222 Stradling Rd.
Moss, Mrs. M. J.
1010 W. Parkway Dr.

O

Owens, Mrs. O. W... 2600 Godman
Owens, Mrs. Richard R.
3011 Oaklyn Ave.
Owens, Mrs. Thomas
608 E. Charles

P-Q

Peacock, Mrs. Robert
R. R. 3, Box 316
Poland, Mrs. U. G... 303 E.
Washington
Quick, Mrs. Wm.
2009 University Ave.

R

Rettig, Mrs. Arthur
611 W. Howard
Rivers, Mrs. Glynn
1334 N. Walnut

S

Saperstein, Mrs. Morris
706 New York Ave.
Schulhof, Mrs. M. G.
921 W. Parkway
Silver, Mrs. Richard
9 Parkway Dr.

Silvers, Mrs. J. C... 319 S. Franklin
Silvers, Mrs. J. M... 220 W. Adams
Smith, Mrs. J. Sylvester,
1006 E. 1st

Stanley, Mrs. John R.
2505 W. Gilbert
Starks, Mrs. William... 825 Haines
Stocking, Mrs. Bruce,
3014 Amherst

T

Tindal, Mrs. E. F... 423 W. Jackson
Tomlin, Mrs. Hugh M.
3115 Amherst

V-W

Venis, Mrs. Kemper... 502 Wade
Wadsworth, Mrs. W. W.
306 E. Jackson
Williams, Mrs. J. H... 905 W. North
Wright, Mrs. C. H... 715 Rex

Y

Young, Mrs. G. S... 114 Berwyn Rd.
Hummel, Mrs. Paul R... Oakville
Hinchman, Mrs. Jean... Parker
Moore, Mrs. Will C... Yorktown

DUBOIS COUNTY

Backer, Mrs. Henry George
Ohio St., Ferdinand
Huntingburg
Amini, Mrs. S... 105 Van Buren
Bretz, Mrs. John... 222 Van Buren
Bretz, Mrs. W. D... 214 Fourth
Steinkamp, Mrs. Emil... 302 Walnut
Stork, Mrs. Harvey K... 523 1st
Williams, Mrs. Fielding... 511 Geiger
Williams, Mrs. Flora... 511 Geiger

DUBOIS COUNTY

(Continued)

Jasper

Greenburg, Mrs. Rolland E.
738 W. 13th
Heck, Mrs. Martin C. 388 W. 15th
Held, Mrs. George A. 716 W. 9th
Klamer, Mrs. Charles H.
424 W. 6th
Wagner, Mrs. Arthur R.F.D. 5

ELKHART COUNTY**Bristol**

Neidballa, Mrs. E. G. R.F.D. 1
Patrick, Mrs. G. B. R.F.D. 1
Schlosser, Mrs. H. C. Seven Gables

Elkhart

Bender, Mrs. R. L. 125 N. Riverside
Billings, Mrs. Elmer

165 Gage Ave.

Bloom, Mrs. George R.

130 Glendale

Bolin, Mrs. Robert S.

1853 East Beardsley

Bowdoin, Mrs. George E.

3809 Greenleaf Blvd.

Compton, Mrs. Walter A.

2225 Greenleaf Blvd.

Conklin, Mrs. R. L. 1906 E. Jackson

Cormican, Mrs. Herbert L.

1621 E. Jackson

Crandall, Mrs. L. A., Jr.

Crandall's Pond, R.F.D. 3

Dovey, Mrs. E. G. 1430 Ervin

Elliot, Mrs. L. A.

R. R. 1, Edwardsburg, Mich.

Elliot, Mrs. Thomas A.

2001 Stevens

Fleming, Mrs. Claude F.

229 W. Jackson

Fleming, Mrs. J. Millard

2220 E. Jackson

Hull, Mrs. A. W. 905 Strong

Hunn, Mrs. M. F. 202 W. Beardsley

Kintner, Mrs. Burton E.

3520 E. Jackson

Koehler, Mrs. Elmer G.

R. R. 1, Edwardsburg, Mich.

Leasure, Mrs. Kenneth E.

320 Cleveland Ave.

Logan, Mrs. Richard. 706 Fulton

Lundt, Mrs. Milo O. 519 S. 2nd

Markel, Mrs. I. J. 215 W. Franklin

Mendez, Mrs. Carlos

325 Superior Blvd.

Miller, Mrs. Hugh A., Jr.

309 E. Crawford

Mininger, Mrs. Edward P.

409 Prospect

Mishkin, Mrs. Irving

217 N. Riverside Dr.

Norris, Mrs. Allen A.

401 W. Marion

Paff, Mrs. Wm. A. 2601 E. Jackson

Paine, Mrs. George D. 329 Meisner

Pancost, Mrs. Vernon

160 Riverview Ave.

Rohr, Mrs. J. H. 1843 Grant

Rupe, Mrs. L. O. 116 W. Dinehart

Sears, Mrs. M. Maywood

R.F.D. 3, West Indiana

Spray, Mrs. Page. 658 Kilbourne

Staufer, Mrs. W. A. 701 Strong

Stout, Mrs. R. B. 1501 Greenleaf

Stubbins, Mrs. William

R.F.D. 1, Dunlap

Swihart, Mrs. Homer R.

220 Meisner

Swihart, Mrs. L. F.

2120 Broadmoor Dr.

Todd, Mrs. David D.

2001 E. Jackson

Wilson, Mrs. O. E.

2505 Greenleaf Blvd.

Work, Mrs. James A., Jr.

4 St. Joseph Manor

Yoder, Mrs. C. Richard

130 N. Corona

Goshen

Amstutz, Mrs. H. C. R. R. 5

Bender, Mrs. C. K. 624 S. 5th

Bigler, Mrs. Fredrick 314 S. 5th

Bosler, Mrs. Howard A.

Waterford Mills, R. R. 5

Chandler, Mrs. L. H. 412 S. 5th

Freeman, Mrs. F. M. 309 E. Wash.

Hostetler, Mrs. C. M. 1602 S. 8th

Martin, Mrs. Floyd S. R.F.D. 5

Nelson, Mrs. D. Chester

1210 S. 8th

Simmons, Mrs. Lloyd H. 606 S. 3rd

Turner, Mrs. John R.F.D. 2

Vander Bogart, Mrs. Harry E.

1411 S. 8th

Wagner, Mrs. D. G. 307 S. 7th

Yoder, Mrs. Albert C. 816 S. 6th

Norris, Mrs. Ernest Middlebury

Nappanee

Fleetwood, Mrs. R. A.

151 E. Van Buren

Kendall, Mrs. F. M. 801 E. Market

Price, Mrs. Douglas W.

458 N. Madison

Slabaugh, Mrs. L. M. 402 N. Main

Slabaugh, Mrs. J. S. 258 N. Main

Fosbrink, Mrs. E. L. Syracuse

Abel, Mrs. Robert Wakarusa

Amick, Mrs. Charles L. Wakarusa

Hannah, Mrs. Jack W. Wakarusa

**FAYETTE-FRANKLIN
COUNTIES****Brookville**

Foreman, Mrs. Walter A. 617 Main

Smith, Mrs. H. N. 812 Main

Seal, Mrs. Perry F. 901 Main

Connersville

Ashworth, Mrs. Juanita

2027 Indiana Ave.

Booher, Mrs. Martha

1609 Virginia Ave.

Brookman, Mrs. Robert E.

2750 Grand Ave.

Clark, Mrs. Helen Nevin

401 Western Ave.

Ellis, Mrs. George M. 516 W. 29th

Fettig, Mrs. Lucille

1609 Virginia Ave.

Fruth, Mrs. Virgil J.

1603 Virginia Ave.

Gregg, Mrs. Albert F.

835 Lincoln Ave.

Kemp, Mrs. W. Alfred. 403 W. 28th

Leffel, Mrs. Glen

1810 Indiana Ave.

Lockhart, Mrs. Jack M.

2918 Vermont Ave.

Metcalf, Mrs. Alma

1805 Virginia Ave.

Moore, Mrs. Hollis. 126½ W. 11th

Morrow, Mrs. Roy D.

629½ Eastern Ave.

Mountain, Mrs. Francis B.

1720 Virginia Ave.

Smelser, Mrs. Herman W.

2530 Grand Ave.

Watterson, Mrs. Gerald T.

1910 Virginia Ave.

FLOYD COUNTY

Engleman, Mrs. H. K. Georgetown

Jeffersonville

Baxter, Mrs. S. M. Centralia

McCullough, Mrs. J. Y. Centralia

Sloan, Mrs. H. P. Lincoln Heights

New Albany

Allen, Mrs. Fred K. 2015 Lindberg

Baker, Mrs. A. M. 2523 Glenwood

Baxter, Mrs. J. W., Jr.

426 Woodrow Ave.

Bird, Mrs. J. E. 1308 E. Spring

Briscoe, Mrs. C. E. 1413 E. Spring

Brown, Mrs. K. H.

1654 Hedden Park

Byrn, Mrs. Howard

330 Beharrel Ave.

Davis, Mrs. Parvin Paoli Pike

Day, Mrs. George. Hausfelt Lane

Edwards, Mrs. W. F.

615 Beharrel Ave.

Garner, Mrs. Wm. H.

922 E. Spring

Hauss, Mrs. A. P. Silver Hills

Hess, Mrs. P. Patrick Lily Lane

Higgins, Mrs. John

Old Vincennes Rd.

LaFollette, Mrs. Robert E.

2510 Glenwood Park

Leuthart, Mrs. C. P.

1410 E. Spring

Pace, Mrs. Jerome

Silvercrest, Old Vincennes Rd.

Paris, Mrs. John M.

2003 Lindberg Ct.

Pierson, Mrs. Percy R. 1430 Silver

Pierce, Mrs. Gene S.

Lynnwood Dr.

Robertson, Mrs. A. N. 323 E. 9th

Rogers, Mrs. S. T. 1017 E. Spring

Streepey, Mrs. Jefferson

1919 Depauw Ave.

Tyler, Mrs. F. T. Daisy Lane

Voyles, Mrs. Harry

425 Beharrel Ave.

Weaver, Mrs. W. W.

1104 E. Spring

Winstandley, Mrs. Wm.

815 Vincennes

Wohlfeld, Mrs. Gerald

Silvercrest, Old Vincennes Rd.

Wolfe, Mrs. Nelson A.

1117 E. Spring

FULTON COUNTY

Miller, Mrs. Virgil C. Akron

Stinson, Mrs. Arthur E. Athens

Bowers, Mrs. Harvey

2552 W. Leland Ave., Chicago 25

Kelsey, Mrs. Lawrence E.

Kewanna

Kraning, Mrs. Kenneth K.

Kewanna

Rochester

Dielman, Mrs. Franklin C.

920 Jefferson

Glackman, Mrs. John C., Sr.

W. 6th

Herendeen, Mrs. Elbie V.

317 W. 7th

King, Mrs. Milo O. 110½ E. 8th

Knotts, Mrs. Slater 328 Clay
 Richardson, Mrs. Chas. L. 506 Pontiac
 Rowe, Mrs. Howard H. 417 W. 9th
 Stinson, Mrs. Dean K. 1318 Main

GIBSON COUNTY

Geick, Mrs. R. G. 207 N. Main, Ft. Branch
 Hollis, Mrs. W. H. 607 E. Locust, Ft. Branch
 Marchand, Mrs. Edwin V. Haubstadt
 Chappell, Mrs. H. R. 119 N. Gibson, Oakland City
 Clark, Mrs. C. M. 511 W. Columbia, Oakland City
 Turner, Mrs. M. A. 322 W. Columbia, Oakland City
 Princeton
 Alexander, Mrs. H. H. 427 W. State

Carpentier, Mrs. H. F. 319 E. State
 Folck, Mrs. J. K. 530 N. Hart
 Graves, Mrs. O. M. 116 E. Spruce
 McCarty, Mrs. Virgil 403 W. Spruce

McElroy, Mrs. R. S. 404 W. Walnut
 Peck, Mrs. J. F. Outer W. Monroe
 Weitzel, Mrs. R. E. 309 W. Spruce

GRANT COUNTY

Malott, Mrs. Fred Converse
 Grant, Mrs. Arthur Fairmount
 Garrison, Mrs. L. J. 305 E. S. "C" St., Gas City

Koontz, Mrs. William A. 315 E. S. "A" St., Gas City
 Marion

Abel, Mrs. Charles Wabash Ave.
 Alderfer, Mrs. Henry 806 W. 1st
 Ayres, Mrs. W. W. 820 Jeffras Ave.

Bloom, Mrs. A. Ward 1111 Euclid Ave.
 Braunlin, Mrs. Robert 315 N. Hill

Comeau, Mrs. Wm. Hickory Hills
 Currie, Mrs. Robert Walnut Hills
 Daniels, Mrs. E. O. 106 N. "E" St.
 Daniels, Mrs. George R. 822 W. Fourth

Davis, Mrs. Merrill S. 723 Euclid Ave.

Davis, Mrs. Richard 1321 W. 4th
 Diamond, Mrs. Leo L. 617 Spencer Ave.

Eshleman, Mrs. L. H. 2923 S. Washington
 Ganz, Mrs. Max 904 Jeffras

Hummel, Mrs. R. M. Shady Hills
 Jarrett, Mrs. John 514 Wabash Ave.

Love, Mrs. V. Logan Hickory Hills

McIlwain, Dr. Eleanor 2107 S. Boots

Powell, Mrs. J. P. 127 River Dr.
 Renbarger, Mrs. Lester Wabash Pike

Rhorer, Mrs. John G. Wabash Ave.
 Simmons, Mrs. F. H. 520 Whites Ave.

Skomp, Mrs. C. E. 1123 Euclid Ave.

Schimmelpfennig, Mrs. R. W. 2119 S. Boots

Warren, Mrs. C. B. 803 W. 6th
 Wicker, Mrs. Eugene 1119 W. 4th

Woodbury, Mrs. J. W. 712 S. "G" St.
 Young, Mrs. Robert, 1911 S. Boots

King, Mrs. P. C. Swayzee
 Taylor, Mrs. E. C. Upland
 Rifner, Mrs. E. S. Van Buren

GREENE COUNTY

Bloomfield
 Cook, Mrs. T. Roy
 Graf, Mrs. Jerome
 Mount, Mrs. M. S.
 Turner, Mrs. H. B.
 Turner, Mrs. J. J.

Jasonville
 Porter, Mrs. Carl
 Rotman, Mrs. Harry
 Rotman, Mrs. Sam

Linton
 Broshears, Mrs. Kenneth
 Craft, Mrs. William
 Fleetwood, Mrs. L. B.
 Hamilton, Mrs. C. C.
 Raney, Mrs. Ben
 Tomak, Mrs. M. E.
 Woner, Mrs. John
 Manzie, Mrs. Michael Lyons

Worthington
 Fender, Mrs. A. H.
 Moses, Mrs. Robert
 Moses, Mrs. George

HAMILTON COUNTY

Donahue, Mrs. C. M. Carmel
 Havens, Mrs. Oscar Cicero
 Ambrose, Mrs. J. C. Noblesville
 Campbell, Mrs. Sam Noblesville
 Harris, Mrs. Robert Noblesville
 Hash, Mrs. J. S. Noblesville
 Kraft, Mrs. H. C. Noblesville
 Shanks, Mrs. Ray Noblesville
 Shonk, Mrs. H. W. Noblesville
 Southard, Mrs. Carl Noblesville
 Connoy, Mrs. Andrew Westfield
 Connoy, Mrs. Leo Westfield

HANCOCK COUNTY

Charlottesville
 Johnston, Mrs. W. R.
 Scott, Mrs. Robert

Fortville
 Manifold, Mrs. Harold

Greenfield
 Allen, Mrs. Joseph 17 E. South
 Endicott, Mrs. Wayne N. East
 Gibbs, Mrs. Charles 203 E. North
 Gill, Mrs. D. D. 328 Park
 Henn, Mrs. R. A. Michigan St.
 Hunter, Mrs. Donn N. East
 Kinneman, Mrs. R. E. 236 W. North

Vingus, Mrs. Bronie 705 N. State
 Woods, Mrs. James R., Jr. 715 N. East

Wyatt, Mrs. L. H. Knightstown
 Pierson, Mrs. Thomas New Palestine

Kuhn, Mrs. Robert Wilkinson
 Treese, Mrs. Nelle Wilkinson

HARRISON-CRAWFORD

COUNTIES

Corydon
 Amy, Mrs. William
 Blessinger, Mrs. Louis

Brockman, Mrs. Wilfred
 Dillman, Mrs. Carl
 Benz, Mrs. Jesse Marengo

HENDRICKS COUNTY

Foltz, Mrs. Lloyd Brownsburg
 Scudder, Mrs. A. N. Brownsburg
 Elliot, Mrs. Paul Danville
 Koch, Mrs. Elmer Danville
 Price, Mrs. Ernest Danville
 Terry, Mrs. Lloyd Danville
 Ellis, Mrs. L. Hall Lizton
 Scamahorn, Mrs. Malcom Pittsboro

Scamahorn, Mrs. Oscar T. Pittsboro
 Aiken, Mrs. Milo Plainfield
 Stafford, Mrs. J. C. Plainfield
 Stafford, Mrs. William C. Plainfield

HENRY COUNTY

Zimmerman, Mrs. W. H. Dublin
 Newnum, Mrs. R. L. Hagerstown
 Dreyer, Mrs. Ralph Knightstown
 Shallenberger, Mrs. H. R. Modoc
 Stauffer, Mrs. George Moreland
 Marshall, Mrs. L. C. Mt. Summit

New Castle
 Amos, Mrs. Robt. L. 924 Lincoln Ave.
 Bitler, Mrs. C. C. 603 S. 11th
 Bledsoe, Mrs. J. G. 319 S. 14th
 Burnett, Mrs. A. B. 1201 S. Main
 Canaday, Mrs. C. E. 1411 Church
 Craig, Mrs. Alex F. Route 2
 Davies, Mrs. Robert R. 1914 Plum St.

Fincher, Jr., Mrs. R. C. Indiana Village
 Fisher, Mrs. John 438 S. 11th
 Foster, Mrs. Ray 420 N. Main
 Harrison, Mrs. B. L. 223 Bundy Ave.

Heilman, Mrs. William C. 1111 Audubon Rd.
 Hill, Mrs. Kenneth G. 100 Leland
 Iterman, Mrs. G. E. 925 Mourer
 Kennedy, Mrs. W. U. 701 S. 14th
 Life, Mrs. Homer L. 1015 W. Broad
 McDonald, Mrs. Frank C. 521 S. Main

McElroy, Mrs. James S. 1213 Audubon Rd.

Saint, Mrs. Wm. K. Crescent Dr.
 Smith, Mrs. Robt. A. 1229 Lincoln
 Stout, Mrs. Walter M. 1103 Audubon Rd.

Thorne, Mrs. Charles E. 1119 S. Main

Vivian, Mrs. Donald E. Crescent Dr.

Wiggins, Mrs. D. S. 219 S. 12th
 Wiggins, Mrs. George, 403 N. Main

Robertson, Mrs. Wm. Spiceland

HOWARD COUNTY

Denton, Mrs. Larkin Greentown
 Shoup, Mrs. H. P. Greentown
 Kokomo

Adams, Mrs. C. J. 1216 W. Superior
 Alward, Mrs. J. H. 401 W. Walnut
 Ault, Mrs. C. H. 321 E. Walnut
 Boughman, Mrs. J. D. 1515 W. Jefferson
 Bowers, Mrs. C. C. 1530 W. Taylor

**HOWARD COUNTY
(Kokomo—Continued)**

Bowers, Mrs. C. B. 421 Morningside
 Bowers, Mrs. J. A. 1535 W. Jefferson
 Bruegge, Mrs. T. J. 1414 Kingston
 Clarke, Mrs. Elton 1400 W. Sycamore
 Conley, Mrs. T. M. 1016 W. Superior
 Craig, Mrs. R. A. 113 Leafy Lane
 Craig, Mrs. Ruben W. Jefferson Rd.
 Crawford, Mrs. T. R. 908 W. Superior
 Cuthbert, Mrs. F. S. 1027 W. Walnut
 Earl, Mrs. M. M. 409 W. Taylor
 Ferry, Mrs. P. J. 1027 W. Sycamore
 Golper, Mrs. M. N. 1021 W. Mulberry
 Good, Mrs. R. P. 417 Conradt
 Halfast, Mrs. Richard 2315 S. Webster
 Hutto, Mrs. O. D. 1012 W. Walnut
 Hutto, Mrs. W. H. 211 Conradt
 Jewell, Mrs. G. M. 1525 W. Walnut
 Kratzer, Mrs. E. F. 320 E. Walnut
 Lung, Mrs. Bruce 115 Conradt
 McIndoo, Mrs. R. E. 820 W. Walnut
 Meiner, Mrs. J. A. 924 W. Wash.
 Morford, Mrs. Guy 1017 W. Superior
 Morrison, Mrs. W. R. 413 Conradt
 Murray, Mrs. E. C. 2200 S. Webster
 Paris, Mrs. D. W. 2417 S. LaFountain
 Phares, Mrs. R. W. 905 W. Mulberry
 Rhorer, Mrs. H. M. 511 W. Sycamore
 Rudicel, Mrs. M. W. 1604 Kingston Rd.
 Schuler, Miss Lucy 502 N. Main
 Schwartz, Mrs. F. C. 1503 Kingston
 Shenk, Mrs. E. M. 306 N. Webster
 Sorenson, Mrs. Raymond 1723 W. Walnut
 Spangler, Mrs. J. S. 2126 S. Webster
 Evans, Mrs. Robert Russiaville

HUNTINGTON COUNTY

Huntington
 Brubaker, Mrs. Harold S. Flaxmill Rd.
 Casey, Mrs. Stanley M. 408 E. Market
 Cope, Mrs. Stanton 1022 N. Jefferson
 Erehart, Mrs. Mark G. 232 W. Market
 Eviston, Mrs. J. Boyd 1392 Poplar
 Gray, Mrs. Paul M. 340 E. Market
 Grayston, Mrs. Fred W. 708 N. Jefferson
 Grayston, Mrs. Wallace S. 303 E. Market
 Haire, Jr., Mrs. T. D. 827 Poplar
 James, Mrs. Thomas, Jr. 1044 Poplar
 Johnston, Mrs. Robert G. 339 E. Market

Marks, Mrs. Howard H. 1433 Cherry
 Mitman, Mrs. Floyd B. 1470 Poplar
 Nie, Mrs. Grover M. 1518 Cherry
 Omstead, Mrs. Trevalyn W. 1511 N. Jefferson
 Ware, Mrs. J. Roger 622 Henry
 Woods, Mrs. Halden C. Markle
 Galbreath, Mrs. Russell S. Rt. 2, South Whitley

Warren

Bennett, Mrs. J. B.
 Black, Mrs. Claude S.
 Smith, Mrs. Lucian W.

**JENNINGS-JACKSON
COUNTIES**

Gillespie, Mrs. G. R. Brownstown
 Shields, Mrs. Jack Brownstown
 Adair, Mrs. W. K. 208 S. Armstrong, Crothersville
 Bard, Mrs. F. B. 305 E. Howard, Crothersville
 Cummings, Mrs. D. J. Ewing
 Scharbrough, Mrs. Wm. Medora
 Calli, Mrs. Louis J. 408 S. State, N. Vernon
 Green, Mrs. John S. Elm, N. Vernon
 Johnson, Mrs. William J. Jackson St.
 Matthews, Mrs. D. W. 147 W. Walnut, N. Vernon
 Thayer, Mrs. Benet Jennings St., N. Vernon
 Seymour
 Black, Mrs. J. M. 315 N. Pine
 Day, Mrs. Durbin 515 W. 6th
 Gillespie, Mrs. Charles E. 602 N. Walnut
 Graessle, Mrs. H. P. 419 N. Walnut
 Kamman, Miss Martha 332 W. Oak
 Martin, Mrs. Guy 1408 Ewing Rd.
 Osterman, Mrs. L. H. 901 Garden Ave.
 Ripley, Mrs. John W. 321 Bruce
 Shortridge, Mrs. W. H. 313 Carter Blvd.
 Wiethoff, Mrs. C. A. 327 Calvin Blvd.

**JASPER-NEWTON
COUNTIES**

Pippenger, Mrs. Wayne G. Brook
 Smith, Mrs. Hunter Goodland
 Mathews, Mrs. W. C. Kentland
 Yegerlehner, Mrs. R. S. Kentland
 Williams, Mrs. Hugh Morocco
 Schantz, Mrs. Richard Remington
 Rensselaer
 Beaver, Mrs. E. R.
 Kresler, Mrs. L. E.
 O'Neill, Mrs. M. J.
 Schumaker, Mrs. Eugene

JAY COUNTY

Heller, Mrs. Nelson L. Dunkirk
 Portland
 Badders, Mrs. Ara C. 709 W. North
 Cripe, Mrs. Wm. H. 507 W. High
 Engle, Mrs. John Max 503 W. Walnut
 Fitzpatrick, Mrs. James S. 420 N. Pleasant

Hammond, Mrs. Stanley M. S. Meridian Street Rd.
 Moran, Mrs. Mark M. 403 E. Walnut
 Morrison, Mrs. George G. North & Park Sts.
 Spahr, Mrs. Donald E. 615 W. Race
 Steffy, Mrs. Ralph 321 E. Race

JEFFERSON COUNTY

Madison
 Alcorn, Mrs. Merritt O. 617 E. Main
 Beetem, Mrs. Luther F. 411 N Broadway
 Childs, Mrs. Wallace Edward Elm & Third
 Hare, Mrs. Frank W. 525 W. Third
 Jolly, Mrs. Lewis Everette J. P. G. Area
 Kemp, Mrs. Milburn W. 412 N. Elm
 May, Mrs. George Arthur R.R. 5
 Petway, Mrs. Allen Paul 411 W. 1st
 Rains, Mrs. Rinda King's Daughters Hospital
 Shuck, Mrs. Wm. A. R.R. 3
 Whitsitt, Mrs. Schuyler 718 W. Main
 Zink, Mrs. Robert Otto 426 Vine

JOHNSON COUNTY

Franklin
 Deppe, Mrs. Charles F. 1215 Park Ave.
 Ferrara, Mrs. Joseph 1000 E. King
 Foster, Mrs. R. H. K. Orchard Grove
 Jones, Mrs. Charles A. E. Adams
 Manuel, Mrs. Donald C. 89 N. Walnut
 Murphy, Mrs. Harry E. 150 N. Main
 Payne, Mrs. Carl F. 151 N. Main
 Portteus, Mrs. Walter L. R. R. 2, Box 11B
 Province, Mrs. Wm. D. R.R. 3
 Records, Mrs. Arthur W. 216 E. Jefferson
 Wilson, Mrs. Russell 351 E. King
 Greenwood
 Brown, Mrs. George E. Beech Park Dr.
 Craig, Mrs. J. A. E. Pearl
 Eaton, Mrs. Lyman D. Springdale Addition
 Machledt, Mrs. John H. 243 S. Madison
 Sheek, Mrs. Kenneth I. 165 N. Brewer
 Tiley, Mrs. George A. 41 N. Madison
 Woodcock, Mrs. Charles W. 240 S. Madison

KNOX COUNTY

Scudder, Mrs. J. A. Edwardsport
 Vincennes
 Anderson, Mrs. Richard M. Monroe City Rd.
 Arbogast, Mrs. Paul B. 1420 Old Orchard Rd.
 Beckes, Mrs. Elsworth W. 220 N. 5th
 Chattin, Mrs. Herbert O. 729 Main

KNOX COUNTY

(Vincennes—Continued)

Coffel, Mrs. Melvin H.
Simpson Lake
Cullison, Mrs. Charles H.
47 Cloverdale
Curtner, Mrs. Myron L. 216 N. 6th
Davis, Mrs. Howard B.
1415 N. 11th
Edwards, Mrs. Edward T., Jr.
1232 N. 11th
Ewing, Mrs. Nathaniel D.
Monroe City Rd.
Fox, Mrs. Maurice S. 704 N. 7th
Green, Mrs. Carl L.
1414 Weed Lane
Humphreys, Mrs. Joe S.
1602 Weed Lane
Keezer, Mrs. Wm. 515 Perry
McCormick, Mrs. Hubert D.
518 N. 4th
McDowell, Mrs. M. M.
1322 Audubon Rd.
McMahan, Mrs. V. C.
Old Wheatland Rd.
Moore, Mrs. Robert G.
1309 Old Orchard Rd.
Reilly, Mrs. James F.
401 Buntin
Richards, Mrs. D. H.
904 Busseron
Schulze, Mrs. Wm. 819 Buntin
Shaffer, Mrs. Kenneth. Ridge Rd.
Small, Mrs. E. F. 526 Scott
Smith, Mrs. Ralph O.
Old Burceville Rd.
Spencer, Mrs. Frederic. 311 N. 9th
Sullenger, Mrs. A. A.
8th & Seminary
Welch, Mrs. Norbert M.
Monroe City Rd.

KOSCIUSKO COUNTY

Urschel, Mrs. Dan L. Mentone
Stalter, Mrs. G. W.
North Webster
Warsaw
Haymond, Mrs. G. M.
532 E. Center
Murphy, Mrs. Samuel C.
216 S. High
Pullman, Mrs. George
E. Winona Ave.
Richer, Mrs. Orville H.
914 E. Main
Roesch, Mrs. Ryland. N. Lake
Schlemmer, Mrs. George H.
528 N. Lake
Thomas, Mrs. E. Winton. E. Main

LAKE COUNTY

Stasick, Mrs. Murray
307-154th Place, Calumet City, Ill.
Crown Point
Becker, Mrs. P. H.
Parramore Hospital
Birdzell, Mrs. J. P.
Ellendale Pkwy.
Hasler, Mrs. N. Ellendale Pkwy.
Horst, Mrs. W. N. 126 N. Court
Klaus, Mrs. J. N. 667 S. Main
Troutwine, Mrs. W. R. S. Main
Carleton, Mrs. E. H.
R.R. 1, Box 175, Dyer
East Chicago
Arnold, Mrs. M. F. 4239 Magoun

Bonaventura, Mrs. Angelo P.
1604 E. 142nd
Ernst, Mrs. H. C. 4219 Baring
Fleischer, Mrs. J. C. 4135 Ivy
Grosso, Mrs. William G.
3502 Grand Blvd.
Gustaitis, Mrs. John W.
4318 Parrish
Johns, Mrs. David R. 1211 Beacon
McGuire, Mrs. Desmond F.
1910 142nd
Niblick, Mrs. James S.
4122 Parrish
Petronella, Mrs. Sam J.
4308 Baring
Shapiro, Mrs. Joseph. 4216 Ivy
Gary
Almquist, Mrs. C. O. 550 Lincoln
Armalavage, Mrs. L. J.
553 Taney
Auten, Mrs. D. S. 553 Lincoln
Behn, Mrs. Walter. 652 McKinley
Bendler, Mrs. Carl H.
225 Morningside
Bills, Mrs. R. N. 534 Lincoln
Brady, Mrs. Samuel J. 451 Garfield
Brandman, Mrs. Harry. 629 Grant
Carbone, Mrs. Joseph
526 Johnson
Chevigny, Mrs. J. J. 654 Johnson
Cooper, Mrs. Leo K. 670 Hayes
Davis, Mrs. Neal
Box 928, Ogden Dunes
Dierolf, Mrs. Edward J.
630 Montgomery
Elliott, Mrs. Ralph A. 1726 W. 6th
English, Mrs. Hubert M. 575 Taft
Goldberg, Mrs. Harold B.
3643 Tyler
Goldstone, Mrs. Joseph
600 Cleveland
Goldstone, Mrs. Sidney R.
566 Taft
Harris, Mrs. Donald M.
4813 Madison
Jannasch, Mrs. M. Clifford
2140 W. 2nd
Kendrick, Mrs. Frank J.
552 Johnson
Kobrin, Mrs. Meyer W.
2300 W. 6th
Kopcha, Mrs. Joseph E. 715 Hayes
Korn, Mrs. Jerome M.
2119 W. 5th
Lebioda, Mrs. Henry S.
230 Morningside
Lewis, Mrs. George N.
463 Taft Place
Lorenty, Mrs. T. B.
3654 Madison
May, Mrs. R. Milton
667 Van Buren
Minczewski, Mrs. R. C. 361 Chase
Molengraft, Mrs. C. J.
544 Monroe
Morris, Mrs. Hyman R.
558 Taney Place
Moswin, Mrs. Jack A. 477 Arthur
Ornelas, Mrs. Joseph P.
230 W. 36th
Palmer, Mrs. Russell H.
2006 W. 4th Place
Reynolds, Mrs. James S.
7300 Maple
Robinson, Mrs. Walter K.
500 N. Montgomery
Rubin, Mrs. Simon S. 2131 W. 5th
Ryan, Mrs. H. J. 630 McKinley

Sala, Mrs. Joseph J. 2333 W. 5th
Sala, Mrs. Walter R. 2035 W. 8th
Senese, Mrs. Thomas J.
581 Johnson
Shevick, Mrs. Alexander
528 Monroe
Slama, Mrs. George F.
3624 Buchanan
Spellman, Mrs. F. W. 640 Illinois
Stimson, Mrs. Harry R.
4338 Jefferson
Thomas, Mrs. Daniel D.
831 Garfield
Thomas, Mrs. G. L. 594 Taney
Verplank, Mrs. G. L.
R. R. 1, 57th & Cleveland
Vye, Mrs. J. Preston
3620 Madison
Weiskopf, Mrs. Henry S.
608 Roosevelt
Yocum, Mrs. Paul S. 578 Roosevelt
Young, Mrs. G. M. 4580 Wash.
Young, Mrs. Robert L.
616 Roosevelt
Watts, Mrs. A. A. 620 Lincoln
Wicks, Mrs. C. O. 560 Van Buren
Griffith
Malmstone, Mrs. Francis A.
114 E. Main
Siekierski, Mrs. Joseph M.
445 Broadway

Hammond

Allegretti, Mrs. Michael L.
6237 Forest
Beconovich, Mrs. Robert. 839 169th
Beilke, Mrs. C. A. 6806 Huron
Brown, Mrs. Stanley Lee
6550 Hohman
Chidlaw, Mrs. B. W.
29 Wildwood Rd.
Cook, Mrs. George M. 6607 Forest
Cotter, Mrs. Edward R.
7225 Knickerbocker
Eggers, Mrs. Henry W.
6542 Hohman
Egnatz, Jr., Mrs. Nicholas
840 Highland
Elledge, Mrs. Ray. 6415 Forest
Fischer, Mrs. Burnell
7403 Van Buren
Gardner, Mrs. H. Glenn
47 Waltham
Gevirtz, Mrs. Milton B.
6528 Forest
Hack, Mrs. Edmund C. 7147 Olcott
Hickman, Mrs. A. Lee, Jr.
614 165th
Hopkins, Mrs. J. R. 265 Conkey
Husted, Mrs. Robert G.
7248 Forest
Komoroske, Mrs. John E.
35 Highland
Koransky, Mrs. David S.
7048 Forest
Kretsch, Mrs. R. W. 7214 Hohman
Lantz, Mrs. Herbert A.
6817 Huron
Lazo, Mrs. Vincente R. 734 Sibley
Marks, Mrs. Ora L. 7111 Olcott
Matthews, Mrs. Charles B.
6416 Forest
Modjeski, Mrs. Raymond J.
223 Locust
Nakadate, Mrs. K. J.
907 173rd Place
Neal, Mrs. L. W. 7507 Olcott
Nelson, Mrs. Richard B. 41 172nd
Panares, Mrs. S. V. 4 172nd Place

LAKE COUNTY

Peck, Mrs. Edward A. 6422 Moraine
 Pilot, Mrs. Jean 7137 Knickerbocker Pkwy.
 Premuda, Mrs. Franklin F. 6545 Alexander
 Remich, Mrs. Antone C. 6412 Moraine
 Rendel, Mrs. Donald T. 18 172nd
 Rhind, Mrs. A. W. 7126 Forest
 Row, Mrs. P. Q. 6706 Hohman
 Rudolph, Mrs. F. G. 216 Lawndale
 Schlesinger, Mrs. J. 7251 Forest
 Shanklin, Mrs. E. M. 14 Ruth
 Stern, Mrs. S. Lewis 226 Oakwood
 Stevens, Mrs. E. W. 6913 Monroe
 Teegarden, Jr., Mrs. J. A. 7204 Woodmar
 Thegze, Mrs. George 7435 Olcott
 Walker, Mrs. A. P. 1135 River
 Wood, Mrs. Frederic H. 5960 Hyslop
 Acos, Mrs. James S. 2844 Garfield
 Markey, Mrs. Richard J. 8740 Cottage Grove, Highland
 Dupes, Mrs. L. E. 727 Main, Hobart
 Murphy, Mrs. J. F. 17634 Maple
 Potts, Mrs. William 3543 Ridge Rd., E., Lansing, Ill.
 Combs, Mrs. L. W. Lowell
 Mirro, Mrs. John A. Lowell
 Munster
 Arbeiter, Mrs. Herbert I. 229 Belden Place
 Arrowsmith, Mrs. James L. 8138 Forest
 Benchik, Mrs. Frank A. 8326 Hawthorn
 Boys, Mrs. F. F. 8517 Crestwood
 Campbell, Mrs. G. G. 211 Ridge Rd.
 Eggers, Mrs. Ernest L. 8147 Meadow Lane
 Friedman, Mrs. I. E. 11 Beverly Place
 Larrabee, Mrs. J. 8143 State Line
 Marks, Mrs. Salvo P. 8320 Parkview
 Rosevear, Mrs. Henry J. 230 Belden
 Sroka, Mrs. Stanley J. 8227 Hohman
 Teplinsky, Mrs. L. L. 222 Beacon Pl.
 Whiting
 Dainko, Mrs. Alfred D. 618 118th
 Jones, Mrs. C. M. 1925 Westpark
 Stecy, Mrs. Peter 1543 Warwick
 Weinberg, Mrs. B. A. 2022 Lake Ave.

LAPORTE COUNTY

Oak, Mrs. D. D., Jr. Hanna
 Oak, Mrs. D. D., Sr. LaCrosse
 LaPorte
 Carter, Mrs. Fred 402 E. Jefferson
 Farnsworth, Mrs. S. A. 117 Fox
 Jones, Mrs. J. C. 2102 Michigan
 Jones, Mrs. R. B. 1515 Indiana
 Kelsey, Mrs. Robert 2107 Monroe
 Kepler, Mrs. Robert W. 1529 Mich.
 Larson, Mrs. G. O. 1006 Monroe
 Muhleman, Mrs. C. E. Greenacres
 Richter, Mrs. J. C. 1421 Indiana
 Wolf, Mrs. John 1412 Indiana

Michigan City

Armstrong, Mrs. T. D. E. Coolspring
 Bankoff, Mrs. M. L. 1412 Wash.
 Bernoske, Mrs. Daniel 731 Pine
 Carlisle, Mrs. M. J. 2212 E. Michigan
 Cleveland, Mrs. John B. 314 Fir
 Fargher, Mrs. F. M. Pottawattomie Park
 Feerer, Mrs. Donald J. 120 Wilshire
 Frost, Mrs. R. J. 817 Pine
 Gardner, Mrs. R. A. Long Beach
 Gilmore, Mrs. Russell 815 Wash.
 Gilmore, Mrs. Robert 216 W. 9th
 Harris, Mrs. Albert J. 2310 Oakenwald, Long Beach
 Jones, Mrs. King 215 E. 2nd
 Kerrigan, Mrs. J. V. E. Coolspring
 Kling, Mrs. Victor Long Beach
 Krieger, Mrs. G. M. 701 Washington
 Kubik, Mrs. F. J. Pottawattomie Park
 Meyer, Mrs. Milo Long Beach
 Piazza, Mrs. L. F. 2402 York
 Pilecki, Mrs. Peter J. 410 Emily
 Plank, Mrs. C. R. Long Beach
 Reed, Dr. Nelle C. 3210 Tilden
 Shortall, Mrs. James P. 2948 Mt. Claireway, Long Beach
 Stumer, Mrs. M. 440 Beverly Ct.
 Feerer, Mrs. Donald 117 W. 7th
 Kohnman, Mrs. B. M. 3011 Franklin
 Kemp, Mrs. John 631 Pine
 Benz, Mrs. O. F. Wanatah
 Hetman, Mrs. M. J. Westville
 Hoover, Mrs. A. W. 2005 Oriole Trail, Long Beach,
 Westville
 Townsend, Mrs. Ralph Beatty Mem. Hospital, Westville
 VanDen Bosch, Mrs. W. c/o Beatty Mem. Hosp., Westville
LAWRENCE COUNTY
 Bedford
 Allen, Mrs. L. Howard 1318 Fourteenth
 Austin, Mrs. Richard P. 1315 Fifteenth
 Benham, Mrs. Lawrence E. Eastern Ave.
 Dusard, Mrs. Joseph C. 1107 N.
 Edmonds, Mrs. Kendrick T. 1303 Fifteenth
 Emery, Mrs. Charles B. 1420 K
 Fountaine, Mrs. Thomas J. 1301 21st
 Hammel, Mrs. Howard T. 1822 Fifteenth
 Kerr, Mrs. Donald M. 2323 Q
 Newland, Mrs. A. E. Hawthorne Pl.
 Noe, Mrs. William R. 1224 Fourteenth
 Scherschel, Mrs. John P. 1713 H
 Smallwood, Mrs. R. B. 1506 Thirteenth
 Wohlfeld, Mrs. J. B. 1124 Sixteenth
 Hamilton, Mrs. James Mitchell
MADISON COUNTY
 Anderson
 Aagesen, Mrs. V. J. Forest Hills
 Armington, Mrs. R. L. Kilbuck Rd.
 Ashcraft, Mrs. J. R. 1225 E. 11th

Ayres, Mrs. Kenneth D. 2210 Meridian
 Austin, Mrs. Maynard A. 238 W. 12th
 Benoit, Mrs. Merrill 3620 Maple Road, Edgewood
 Bixler, Mrs. Donald P. 1008 E. 38th
 Blassaras, Mrs. Crist A. Forest Hills
 Brock, Mrs. Earl E. Madison Heights
 Brown, Mrs. James M. 727 E. 31st
 Buckles, Mrs. David L. 44 Knoll Rd., Edgewood
 Dixon, Mrs. Rex W. 936 W. 8th
 Donaldson, Mrs. Frank C. 1728 W. 10th
 Drake, Mrs. John C. Madison Heights
 Ellis, Mrs. Seth W. Forest Hills
 Elsten, Mrs. Wayne A. 1333 Maryland Dr., Forest Manor
 Erehart, Mrs. Archie D. 1221 Irving Way
 Fischer, Mrs. Warren E. Grandview Terrace
 Gante, Mrs. Henry W. 2005 Nichol
 Hart, Mrs. Wm. D. 1026 W. 8th
 Hensler, Mrs. Benton M. 717 Winding Way, Edgewood
 Jones, Mrs. Albert T. 1930 W. 12th
 Kelly, Mrs. Wendell C. 23 Colony Rd., Edgewood
 King, Mrs. Joseph W. 260 Davis Drive, Edgewood
 Larmore, Mrs. Joseph L. 1301 Winding Way, Edgewood
 Litzenberger, Mrs. Sam W. Forest Hills
 Long, Mrs. Paul L. Forest Hills
 McDonald, Mrs. Virgil C. Country Club Estates
 Metcalf, Mrs. George B. 830 W. 8th
 Neale, Mrs. Alfred E. 630 Madison
 Nesbitt, Mrs. Leonard L. R.R. 6, Box 10, 8th Street Rd.
 Patterson, Mrs. William K. 2747 Nichol
 Polhemus, Mrs. Warren C. 1800 W. 11th
 Rosenbaum, Mrs. Lloyd E. Forest Hills
 Ross, Mrs. Guy E. Madison Heights
 Rozelle, Mrs. Clarence V. Forest Hills
 Sharp, Mrs. William L. Country Club Estates
 Wilkinson, Mrs. Roger L. 1525 Winding Way, Edgewood
 Wishard, Mrs. Fred B. 505 W. 9th
 Zierer, Mrs. Reuben O. Woodlawn Heights
 Drake, Mrs. Marion C. Elwood
 Scea, Mrs. Wallace A. 1402 S. F St., Elwood
 Bishop, Mrs. Harry A. Frankton
 Williams, Mrs. Robert D. Markleville
 McLaughlin, Mrs. Calvin P. Pendleton
 Williams, Mrs. Francis M. Pendleton
 Van Ness, Mrs. William Summitville

MARION COUNTY

Ramage, Mrs. Walter F.
244 S. 1st, Beech Grove
Tyner, Mrs. Harlan H. . . . Clayton
Indianapolis

A

Adkins, Mrs. Harold C.
250 W. Hampton Drive
Albertson, Mrs. Frank P.
5031 Rockville Rd.
Alvis, Mrs. Edmond O.
8000 Morningside Dr.
Appel, Mrs. Richard H.
4465 Marcy Lane, No. 190
Arbogast, Mrs. John L.
3516 Carrollton
Arbuckle, Mrs. William E.
1759 W. Morris

B

Bachmann, Mrs. Arnold J.
3239 Winfield
Bakemeier, Mrs. Otto H.
5535 E. St. Clair
Ball, Mrs. Joseph E. 823 N. Lesley
Bartley, Mrs. Max D. . . . 107 E. 48th
Batman, Mrs. Gordon W.
6906 N. Delaware
Beasley, Mrs. Thos. J.
112 Berkley Rd.
Beaver, Mrs. Howard W.
R.R. 6, Box 158
Berman, Mrs. Jacob K.
1105 W. Kessler Blvd.
Bibler, Mrs. Lester D.
3821 Guilford
Blatt, Mrs. A. Ebner
5330 N. Illinois
Bowman, Mrs. George W.
5634 Carrollton
Boyer, Mrs. Floyd A.
136 S. Wittfield
Brady, Mrs. Thomas A.
225 Wellington Rd.
Brayton, Mrs. John R.
3128 E. Fall Creek Blvd.
Brayton, Mrs. Lee
5540 N. Illinois
Brodie, Mrs. Donald W.
R.R. 12, Box 241 M
Brown, Mrs. Edward A.
5420 Central
Brown, Mrs. Wendell,
3750 N. Gale
Browning, Mrs. William M.
2275 Wynnedale Rd.
Brubaker, Mrs. E. H. . . . 624 E. 23rd
Bunde, Mrs. Carl A.
952 N. Downey
Burghard, Mrs. Rolla . . . 2171 E. 67th

C

Cahal, Mrs. Ernest E. . . . 27 E. 39th
Cahn, Mrs. Hugo M. . . . 3038 Park
Call, Mrs. Herbert F. . . . 710 E. 57th
Campbell, Mrs. John A.
5201 Grandview
Carlson, Mrs. Charles E.
6130 N. Carvel
Carson, Mrs. E. Wayne,
7177 N. Meridian
Carter, Mrs. Larue D.
4280 N. Meridian
Carter, Mrs. Oren E.
5461 Kenwood
Clark, Mrs. Lawson J.
2425 E. Kessler Blvd.
Cohn, Mrs. A. F. . . . 1120 S. View Dr.

Conley, Mrs. Joseph L.
1617 E. Ohio
Conway, Mrs. Glenn,
2235 E. Garfield Dr.
Cornacchione, Mrs. Matthew
5703 Broadway Terrace
Cortese, Mrs. James V.
124 W. Troy
Cortese, Mrs. Thomas A.
3240 Brill Rd.
Countryman, Mrs. F. W.
5633 Central
Cox, Mrs. Clifford E.
R.R. 16, Box 593
Craven, Mrs. Howard T.
730 E. 52nd
Cuthbert, Mrs. Marvin
5611 N. Delaware

D

Davidson, Mrs. N. Cort
6901 Washington Blvd.
Davis, Mrs. Sam J. . . . 5114 Park
Day, Mrs. Clark 29 W. 42nd
Dearmin, Mrs. Robert M.
5147 N. Delaware
DeArmond, Mrs. Albert M.
5401 N. Delaware
Deever, Mrs. John W.
R.R. 6, Box 528
Denny, Mrs. James W.
84 N. Audubon Rd.
DeWees, Mrs. Dwight L.
302 N. Bradley
Donato, Mrs. Albert M.
4225 South East
Dorman, Mrs. W. Leland
R.R. 9, Box 157
Dugan, Mrs. William M.
5747 Rolling Ridge Rd.
Dyar, Jr. Mrs. Edwin W.
5910 Washington Blvd.

E

Eastman, Mrs. Joseph R., Jr.
8217 Spring Mill Rd.
Eastman, Mrs. Joseph Rilus
8160 N. Meridian
Eaton, Mrs. Edwin R.
5750 Allisonville Rd.
Ebert, Mrs. J. Wayne
1125 Southview Dr.
Egbert, Mrs. Herbert L.
3210 Washington Blvd.
Eicher, Mrs. Palmer O.
4401 Washington Blvd.
Eldridge, Mrs. Gail E.
5746 Central
Ellis, Mrs. Bert E.
R.R. 2, Box 247
Emhardt, Mrs. John T.
3305 Brill Rd.
Emhardt, Mrs. John W.
5424 Washington Blvd.
Ensminger, Mrs. Leonard A.
1321 N. Meridian
Ernst, Jr. Mrs. Clifford E.
3206 N. Sharon
Evans, Mrs. Paul V.
5725 Indianola
Everly, Mrs. Ralph V. . . . 1105 E. 58th

F

Fausset, Mrs. C. Basil
5236 Graceland
Flanigan, Mrs. Meridith B.
2920 W. 33rd
Flora, Mrs. Joseph O.
R.R. 2, Box 599
Folkening, Mrs. Norval C.
5501 Camden

Frazin, Mrs. Bernard . . . 1481 W. 10th
Fouts, Mrs. Paul J. 8393 N. Illinois
Fry, Mrs. Robert D.
5717 Broadway

G

Gabe, Mrs. William E.
502 W. Hampton Dr.
Gambill, Mrs. Wm. Dudley
R.R. 17, Box 66
Garber, Mrs. J. Neill, 1101 E. 57th
Garceau, Mrs. George J.
4334 N. Pennsylvania
Gardiner, Mrs. Sprague H.
330 W. 62nd
Gardner, Mrs. F. Buckman
315 W. Hampton Dr.
Garfield, Mrs. Martin
3704 Watson Rd.
Garner, Mrs. W. Stanley
3785 E. 62nd
Garrett, Mrs. John D.
2523 Central
Garrett, Mrs. Robert A.
5242 Boulevard Place
Gastineau, Mrs. David C.
8620 Manderley Dr.
Gastineau, Mrs. Frank M.
5344 N. Pennsylvania
Geider, Mrs. Roy A.
5816 Pleasant Run Pkwy.
George, Mrs. Charles, 1121 E. 80th
Gick, Mrs. Herman H.
451 Eastern
Gifford, Mrs. Fred E.
5125 N. Meridian
Gillespie, Mrs. Charles F.
2615 E. 35th
Goldman, Mrs. Samuel
5632 Rosslyn
Gosman, Mrs. James H.
340 E. Maple Rd.
Greist, Mrs. John H.,
4343 Washington Blvd.
Griffith, Mrs. Richard S.
1676 Winton
Griffith, Mrs. Ross E.
4452 Washington Blvd.
Grisell, Mrs. Ted L.
5411 Broadway
Gustafson, Mrs. Gerald W.
5768 N. Pennsylvania

H

Habich, Mrs. Carl 44 E. 52nd
Hadley, Mrs. David
3132 N. New Jersey
Haggard, Mrs. Edmund B.
3481 Birchwood
Hahn, Mrs. E. Vernon
R.R. 2, Box 376
Hall, Mrs. Frank 6969 College
Hall, Mrs. Jack R.
4061 Washington Blvd.
Hamer, Mrs. Homer G.
4454 N. Pennsylvania
Hampshire, Mrs. Donald
4378 Central
Hanley, Mrs. Edward J.
5260 Ralston
Hanna, Mrs. Thomas A.
5009 W. 15th
Hansell, Mrs. Robert M.
3525 N. Gladstone
Harcourt, Mrs. Allan K.
4915 N. Illinois
Harding, Mrs. M. Richard
2830 W. 33rd
Harding, Mrs. Myron S.
46 W. 46th

MARION COUNTY (Indianapolis—Continued)

Harold, Mrs. Albert H.
7510 Allisonville Rd.
Harold, Mrs. Norris E.
3545 N. Denny
Haslinger, Mrs. Clarence J.
5236 Boulevard Place
Hawk, Mrs. James H.
4485 N. Pennsylvania
Haymond, Mrs. Joseph L.
551 E. 36th
Hays, Mrs. Everett L.
2607 Manker
Hedricks, Mrs. Philip W.
652 E. 54th
Helmer, Mrs. O. M.
5015 N. Illinois
Hendricks, Mrs. John W.
124 W. 64th
Hepburn, Mrs. Charles K.
7570 Morningside Dr.
Hetherington, Mrs. A. M.
4421 E. Washington, No. 38
Heubi, Mrs. John E.
5061 N. Illinois
Hickman, Mrs. Walter F.
3107 N. Meridian, Apt. E
Hilddrup, Mrs. Don G.
5672 N. Illinois
Hoffman, Mrs. Herman
7002 Park
Holman, Mrs. Jerome E., Jr.
5359 Guilford
Holman, Mrs. Jerome E., Sr.
R.R. 13, Box 73
Hood, Mrs. Ainslee A.
5059 S. Harlan
Horwitz, Mrs. Thomas
6720 Allisonville Rd.
Howell, Mrs. Joseph D.
3431 Winthrop
Howell, Mrs. Robert D.
3641 N. Pennsylvania
Hudson, Mrs. Foster J.
525 W. Hampton Dr.
Hughes, Mrs. James E.
2534 Broadway
Hughes, Mrs. William F., Sr.
4025 N. Meridian
Hull, Mrs. Ronald
2220 Douglas

I-J
Irwin, Mrs. Glenn W., Jr.
5022 Graceland
Jaeger, Mrs. Alfred S.
2935 Washington Blvd.
Jaquith, Mrs. Orville S.
261 Blue Ridge Rd.
Jay, Mrs. Arthur N.
815 W. 64th
Jennings, Mrs. Frank
Sunnyside Sanatorium
Jewett, Mrs. Joe H., 4907 Rosslyn
Jinks, Mrs. Clifford H.
5740 Carrollton
Jobs, Mrs. James E.
R. R. 17, Box 43
Johnson, Mrs. Thomas W.
5735 Washington Blvd.
Jones, Mrs. David E.
646 Berkley Rd.
Joseph, Mrs. Rex M.
R. R. 6, Box 524

K
Kammen, Mrs. Leo
257 W. 46th
Katterjohn, Mrs. James
5867 Central Ave.
Kauffman, Mrs. Nelson N.
5970 Central

Keenan, Mrs. Reid L.
3702 N. Delaware
Keiser, Mrs. V. D.
5709 Broadway
Kelly, Mrs. Don E.
4927 Kenwood
Kelly, Mrs. Walter F.
6845 E. Pleasant Run Pkwy.
Kempf, Mrs. Gerald F.
General Hospital
Kennedy, Mrs. Hunter
757 N. Bolton
Kerr, Mrs. Harry R.
5774 Washington Blvd.
Kime, Mrs. Edwin N.
239 Buckingham Dr.
Kingsbury, Mrs. John K.
5776 E. Michigan
Kirklin, Mrs. Oren L.
8005 Englewood Rd.
Kirtley, Mrs. Wm. R.
730 E. 73rd
Kiser, Mrs. Edgar F.
5610 Central
Kitterman, Mrs. Harry E.
5108 Graceland
Klain, Mrs. Benjamin V.
5775 Central
Knowles, Mrs. Charles Y.
1121 N. Downey
Knowles, Mrs. Robert P.
5825 Norwaldo
Kohlstaedt, Mrs. Kenneth G.
645 E. 80th
Koons, Mrs. Karl M.
5767 N. Penn.
Kornafel, Mrs. L. H.
6201 College
Kraft, Mrs. Bennett
7025 Washington Blvd.
Kuntz, Mrs. Herman W.
1418 N. Butler
Kurtz, Mrs. Philip L.
6841 Willow Rd.
Kwitney, Mrs. I. J.
5774 Broadway Terrace

L

LaDine, Mrs. Clarence B.
4221 E. 35th
Lamb, Mrs. Emmett B.
1180 Golden Hill Dr.
Lamb, Mrs. Russell W.
4636 N. Capitol
Lamber, Mrs. Chet K.
1501 E. Maple Rd., Apt. 19
Lawler, Mrs. George F.
5601 E. St. Clair
Leasure, Mrs. J. Kent
3115 N. Meridian
Leff, Mrs. Abe H.
46 W. 52nd
Lefler, Mrs. W. T.
5515 N. Illinois
Levi, Mrs. Leon
402 W. Hampton Dr.
Lewis, Mrs. Robert J.
3742 N. Denny
Lichtenberg, Mrs. Melvin
4021 N. New Jersey
Lingeman, Mrs. R. E.
2434 E. 58th, S. Dr.
Link, Mrs. Goethe
2609 Putters Lane
Lochry, Mrs. Ralph L.
6150 Crows Nest Dr.
Lord, Mrs. Glenn C.
4455 Washington Blvd.
Love, Mrs. George N.
1644 N. Delaware
Ludwig, Mrs. Oscar D.
5433 Madison
Lybrook, Mrs. William B.
R. R. 13, Box 72

M

McBride, Mrs. James S.
7048 Warwick Rd.
McClain, Mrs. Edwin S.
2150 Napoleon
McCown, Mrs. Percy E.
5008 N. Meridian
McGrath, Mrs. Michael F.
6183 Washington Blvd.
McGuff, Mrs. Paul
3545 College
McIntire, Mrs. Clarence R.
4520 Marcy Lane, No. 27
McQuiston, Mrs. Ralph J.
R. R. 15, Box 385
McTurnan, Mrs. Robert W.
5957 Kingsley Dr.
MacGregor, Mrs. Donald E.
6080 N. Michigan Rd.
Mackey, Mrs. John E.
629 E. 32nd
Magennis, Mrs. Herbert L.
3010 E. 38th, No. 14
Manalan, Mrs. M. M.
3007 E. 39th, No. 60
Manion, Mrs. Marlow W.
5132 N. New Jersey
Mann, Mrs. Mortimer
28 E. 55th
Manning, Mrs. Joseph C.
3121 Sharon
Marshall, Mrs. Albert L. Jr.
4149 Central Ave.
Marshall, Mrs. Cavins R.
6120 N. Michigan Rd.
Martin, Mrs. Loren H.
5338 Washington Blvd.
Martz, Mrs. Carl D.
4571 Fall Creek Blvd., S. Dr.
Masters, Mrs. John M.
34 E. 46th
Matthew, Mrs. W. Burleigh
3462 E. Fall Creek Blvd., N. Dr.
Matthew, Mrs. William
943 N. Franklin Rd.
Megenhardt, Mrs. Dennis
3038 E. Fall Creek Blvd.
Mericle, Mrs. Earl W.
4480 N. Meridian
Merrell, Mrs. Paul
5637 Kenwood
Mertz, Mrs. John H. O.
723 Clarendon Pl.
Micheli, Mrs. Arthur J.
1501 E. 38th, No. 3
Miller, Mrs. Raleigh S.
6140 College
Millikan, Mrs. William J.
2620 E. 59th
Mitchell, Mrs. Earl H.
2263 E. Riverside Dr.
Mitchell, Mrs. Edward O.
4526 Washington Blvd.
Moenning, Mrs. Walter P.
7030 N. Pennsylvania
Molt, Mrs. William F.
2315 N. Talbot
Montgomery, Mrs. William F.
4546 Park
Moore, Mrs. Harold T.
3220 Sharon
Moore, Mrs. Robert M.
5617 N. Meridian
Morchan, Mrs. Samuel
7007 Broadway
Morrison, Mrs. Lewis E., II
4450 Park Ave.
Morton, Mrs. Walter P.
3434 E. Fall Creek Blvd., N. Dr.
Moser, Mrs. Rollin H.
6220 Sunset Lane
Myers, Mrs. Roy V.
R. R. 13, Box 75

MARION COUNTY (Indianapolis—Continued)

N
Nafe, Mrs. Cleon 5060 N. Meridian
Nay, Mrs. Richard M. 5257 Hinesley
Need, Mrs. Louis T. 3627 Bluff Rd.
Nester, Miss Lena Laura 2832 N. Capitol
Nie, Mrs. Louis W. 4305 Central
Noble, Jr., Mrs. Thomas B. 4360 N. Pennsylvania
Nolting, Mrs. Henry F. 155 W. Hampton Dr.
Norman, Mrs. William H. 6416 Dean Rd.
Nourse, Mrs. Myron 5251 Primrose
Nugent, Mrs. Edwin J. 2266 Wynnedale Rd.
O
Ochsner, Mrs. Harold C. 405 E. 45th
Olvey, Mrs. Ottis N. 5428 Central Ave.
Otten, Mrs. Claude F. 4456 Central
Ottinger, Mrs. Ross C. 5211 N. Meridian
Owen, Mrs. John E. 4429 N. Illinois
Owens, Mrs. Tracy 2823 N. Meridian
P
Pandolfo, Mrs. Harry 529 Markwood
Patton, Mrs. Martin T. 3060 N. Meridian, Apt. 504
Paulissen, Mrs. George T. 741 Markwood
Paynter, Mrs. Morris B. 115 Roberts Road
Pearson, Mrs. Lyman R. Marott Hotel, No. 624
Peck, Mrs. Franklin B. 5826 Winthrop
Pennington, Mrs. Walter E. 4420 N. Meridian
Permer, Mrs. Erwin 3018 N. Delaware
Peters, Mrs. Robert J. D. 3203 E. Michigan
Pickett, Mrs. Robert 129 W. 41st
Pollack, Mrs. Lewis 5658 Guilford
Popplewell, Mrs. A. G. Sunnyside Sanatorium
Price, Mrs. Francis W. 2405 Union
Pryor, Mrs. Richard 6134 Carrollton
R
Rabb, Mrs. Albert M. 4146 N. Illinois
Rader, Mrs. George S. 3778 E. 62nd
Ramsey, Mrs. Frank B. R. R. 17, Box 161
Reed, Mrs. Phillip B. 4131 N. Meridian
Rees, Mrs. Russell C. 926 Ellenberger Pkwy., W. Dr.
Reid, Mrs. Charles A. 6512 Madison
Rice, Mrs. Raymond M. 5365 N. New Jersey
Richardson, Mrs. Thad T. 408 N. Arlington
Ricketts, Mrs. Joseph W. 5349 Kenwood
Rigg, Mrs. John F. 5115 N. Meridian

Ritchey, Mrs. James O. 43 W. 43rd
Robb, Mrs. John A. 5254 Broadway
Rogers, Mrs. Donald L. 3031 N. Centennial
Rohn, Mrs. Robert J. 3740 Forest Manor Ave.
Roller, Mrs. Charles W. 2301 Garfield Dr.
Romberger, Mrs. Floyd T. Jr. 370 W. 52nd
Rosenak, Mrs. Bernard D. 5254 N. Delaware
Ross, Mrs. Alexander T. 265 W. Westfield Blvd.
Row, Mrs. D. Hamilton 5214 Grandview Dr.
Ruddell, Mrs. Karl R. 2626 N. Meridian
Ruddell, Mrs. Keith 1321 N. Meridian
Rudolph, Mrs. Stephen J. 3421 N. Kinnear
Rupel, Mrs. Ernest 701 Kessler Blvd., W. Dr.
Rust, Mrs. Byron K. 8120 Sycamore Rd.
Ryan, Mrs. Glen V. 3168 E. Fall Creek Pkwy., N. Dr.
S
Sage, Mrs. Russell A. R. R. 14, Box 221
Salb, Mrs. Max C. 6741 Allisonville Rd.
Sanders, Mrs. Harry M. 3443 N. DeQuincy
Schechter, Mrs. John 4966 Kingsley Dr.
Schneider, Mrs. Carl J. 340 N. Kenyon
Schuchman, Mrs. Gabriel 5944 Central
Schuster, Mrs. Dwight 5042 N. Capitol
Scott, Mrs. George E. 3636 Layman
Scott, Mrs. Robert P. 5011 Winthrop Ave.
Sedam, Mrs. Herbert L. 6931 Central
Sexson, Mrs. Hiram T. 5455 N. Meridian
Shafer, Mrs. Marion R. 6290 Allisonville Rd.
Sheehan, Mrs. Francis G. 950 Graham
Shugart, Mrs. Joseph A. 3610 Watson Rd.
Shumacker, Mrs. H. B. Jr. 4330 N. Central
Sicks, Mrs. Okla 5609 N. Pennsylvania
Sidebottom, Mrs. Earl W. 2820 W. 29th
Siekerman, Mrs. C. W. 1604 Loretta
Sigmond, Mrs. Harvey W. 3245 N. Pennsylvania
Sims, Mrs. J. Lawrence 3723 N. Gale
Sluss, Mrs. David 3657 Washington Blvd.
Smith, Mrs. David L. Williams Creek
Smith, Mrs. E. Rogers 4725 Central Ave.
Smith, Mrs. Lester A. 126 Berkley Rd.

Smith, Mrs. Roy Lee R. R. 6, Box 473
Solomon, Mrs. R. A. 5330 N. Pennsylvania
Sovine, Mrs. J. W. 8182 N. Illinois
Spahr, Mrs. John F. Jr. 3845 N. Meridian
Sparks, Mrs. Alan L. 4310 Central
Spath, Mrs. C. B. Jr. 5671 Rolling Ridge Rd.
Spath, Mrs. Carl B. Sr. 7860 Barlum Dr.
Stadler, Mrs. Harold E. 6244 Washington Blvd.
Stanley, Mrs. John 3814 E. 30th
Stayton, Mrs. Chester A. Jr. 5260 Cornelius
Stayton, Mrs. Chester A. Sr. 6925 N. Delaware
Stephens, Mrs. Donald E. 5555 Broadway
Sterne, Mrs. S. Gloria Continental, No. 317
Stevens, Mrs. Sydney L. 3430 N. Temple
Stoelting, Mrs. V. K. 3730 N. Gale
Stone, Mrs. A. T. 5727 Broadway
Storey, Mrs. D. Edmund 1320 N. Delaware
Stout, Mrs. F. Eugene 3225 Medford
Stroup, Mrs. Tyler J. 5758 College
Stucky, Mrs. Elsworth K. 3602 Watson Rd.
Stygall, Mrs. James H. 4311 N. Meridian
Sudranski, Mrs. Herbert F. 3614 Guilford
Sutton, Mrs. William E. 5670 Guilford
Swan, Mrs. John R. 320 Arden Dr.
Symmes, Mrs. Alfred T. 717 W. 44th
Szynal, Mrs. John S. 1841 Warman
T
Talbot, Mrs. Dan E. 6470 N. Michigan Rd.
Tanner, Mrs. Henry S. 4461 N. Pennsylvania
Taube, Mrs. Jack 715 E. 50th
Taylor, Mrs. Clifford 5938 Crittenden
Taylor, Mrs. Frederick W. 40 E. 43rd
Teague, Mrs. Frank W. 8000 Sycamore Rd.
Tether, Mrs. J. Edward 2206 Lafayette Rd.
Tharp, Mrs. Harold R. 5302 E. St. Clair
Tharpe, Mrs. Ray 6161 Sunset Lane
Thatcher, Mrs. Hugh K. Jr. 745 W. 44th
Thomas, Mrs. Lowell I. 28 W. Hampton Dr.
Thomas, Mrs. Morris E. 5207 N. New Jersey
Thompson, Mrs. Charles F. 6038 N. Olney
Thompson, Mrs. John V. 7899 Ridge Rd.
Thornburg, Mrs. K. E. 4702 Washington Blvd.
Thurston, Mrs. A. L. 421 E. 41st

MARION COUNTY (Indianapolis—Continued)

Tindall, Jr., Mrs. G. T.
964 Ellenberger Pkwy., W. Dr.
Tinsley, Mrs. Walter B.
3314 Carrollton
Torrella, Mrs. Jose A. 5721 W. 18th
Trusler, Mrs. Harold M.
6150 N. Pennsylvania
Tuchman, Mrs. Joseph H.
1154 Hawk Lane
Tucker, Mrs. Robert L.
5075 Norwaldo
V
Vandivier, Mrs. Robert M.
4738 Boulevard Pl.
Van Meter, Mrs. C. Powell
4102 Marrison Place
VanOsdol, Mrs. Harry A.
43 Hampton Drive
Vollrath, Mrs. Victor J.
5204 N. Illinois
Voyles, Mrs. Charles F.
4150 N. Meridian
W
Waldo, Mrs. J. Thayer
8383 N. Illinois
Walker, Mrs. Frank C.
5563 N. Pennsylvania
Walther, Mrs. Joseph E.
4266 N. Pennsylvania
Warvel, Mrs. John H.
4360 Kessler Blvd., N. Dr.
West, Mrs. Joseph L.
2110 W. 38th
Westfall, Mrs. B. Kemper Jr.
6601 College
Westfall, Mrs. John B. 32 E. 46th
White, Mrs. Donald J.
5430 N. Delaware
White, Mrs. John B.
3942 N. Adams
Wilkens, Mrs. Irvin W.
4816 Pleasant Run Pkwy.
Williams, Mrs. Howard S.
3908 Guilford
Wilmore, Mrs. Ralph C.
6015 Evanston
Wilson, Mrs. Oliver R.
3519 Washington Blvd.
Winters, Mrs. Matthew
4044 Carrollton
Wise, Mrs. William
4934 N. Pennsylvania
Wishard, Mrs. William N. Jr.
4150 N. Illinois
Wolfram, Mrs. Don J.
5716 N. Pennsylvania
Wooling, Mrs. Kenneth R.
5303 Blvd. Pl.
Worley, Mrs. J. P.
5295 E. Pleasant Run Pkwy.,
S. Dr.
Wright, Mrs. J. William Jr.
2115 Wilshire Rd.
Wytttenbach, Mrs. John E.
5509 Kenwood
Y-Z
Young, Mrs. James W.
440 E. 71st
Young, Mrs. John E.
6161 Nimitz Dr.
Young, Mrs. John M.
4525 Marcy Lane
Young, Mrs. Woodson C.
3215 Medford
Zell, Mrs. Evertson H.
3110 Sutherland Ave.

Stephens, Mrs. K. H. Lawrence
Miller, Mrs. Ray D.
290 E. Washington, Martinsville
New Augusta
Asher, Mrs. Ernest O. Box 4
Asher, Mrs. James W.
Brown, Mrs. David E. R. R. 1
Brown, Mrs. DeWitt W.
R. R. 1, Box 268
Spivey, Mrs. Russell J. R. R. 1
Tinney, Mrs. Wm. E.
No. 106, 22nd, P. O. Box 1186,
Pass-a-Grille, Florida
Jones, Mrs. George L. Wanamaker
Bailey, Mrs. Lawrence S.
110 S. Second, Zionsville

MARSHALL COUNTY

Seller, Mrs. Tom G. Argos
Graham, Mrs. C. R. Bourbon
Bowen, Mrs. Otis R. Bremen
Witham, Mrs. Robert L. Culver
Plymouth
Danielson, Mrs. Harry L.
Irey, Mrs. Paul R.
Klingler, Mrs. M. O.
1111 Ferndale Ave.
Kubley, Mrs. James
Pomeroy, Mrs. Rex
Reid, Mrs. Robert G. 109 Baker

MIAMI COUNTY

Shrock, Mrs. E. E. Amboy
Line, Mrs. Homer Chili
Macy
Sennett, Mrs. W. K.
Waite, Miss Carrie
Waite, Miss Margaret
Rendel, Mrs. C. F. Mexico
Rendel, Mrs. H. E. Mexico
Peru
Baldwin, Mrs. C. A.
17½ S. Huntington
Barnett, Helen. 109 W. 7th
Berkebile, Mrs. John. 15 W. 6th
Carl, Mrs. Clara. 128 W. 3rd
Eikenberry, Mrs. B. F. 28 W. 6th
Herd, Mrs. C. R. 115 E. 5th
Johnson, Mrs. Owen B. 181 E. 6th
Malouf, Mrs. S. D. 359 W. 3rd
Wagner, Mrs. Sarah. R. R. 4
Wildman, Mrs. R. E. R. R. 2
Yarling, Mrs. Francis. 117 E. 5th

MONTGOMERY COUNTY

Suzuki, Mrs. Tsutomu T.
Covington
Crawfordsville
Ball, Mrs. T. Z. 401 S. Washington
Burks, Mrs. Jess E. 411 S. Walnut
Cooksey, Mrs. Thomas L.
206 Marshall
Cornell, Mrs. Robert A.
1000 S. Washington
Daugherty, Mrs. Fred N.
415 W. Main
Haller, Mrs. Thomas C.
508 W. Main
Humphreys, Mrs. John W.
206 Woodlawn
Kinnaman, Mrs. Howard A. R. R. 6
Kirtley, Mrs. James M.
615 Thornwood Rd.

Lingeman, Mrs. Byron J.
203 Wallace
Mount, Mrs. William M.
1417 W. Main
Peacock, Mrs. Norman F.
107 Vernon Court
Pierson, Mrs. Robert H.
305 E. Main
Sharp, Mrs. John L. 1403 E. Main
Wallace, Mrs. Hawthorne C.
107 W. Jefferson
Otten, Mrs. Ralph R. Darlington
Priebe, Mrs. Fred. Hillsboro
Smith, Mrs. Byron J. Kingman
Ladoga
Blix, Mrs. Fred
Denny, Mrs. Frank T.
Walterhouse, Mrs. H. H.
Davis, Mrs. William H.
New Market
Kindell, Mrs. Herschel D.
New Richmond
Gwaltney, Mrs. L. F. Roachdale
Richards, Mrs. Edgar E.
Russellville
Himebaugh, Mrs. Gilbert
Veedersburg
Rusk, Mrs. Hubert M. Wallace
Hendrix, Mrs. Claude. Waveland
Johnson, Mrs. Dale. Waynetown
Parker, Mrs. Carl B. Wingate

MORGAN COUNTY

Martinsville
Eisenberg, Mrs. David
340 E. Cunningham
Gray, Mrs. Leon. 260 N. Ohio
Miller, Mrs. Ray
290 E. Washington
Pitkin, Mrs. Edward M.
309 E. Washington
Pitkin, Mrs. McKendree C.
440 E. Washington
Sweet, Mrs. Austin 260 N. Wayne
Van Wienan, Mrs. John
189 S. Jefferson
Willan, Mrs. Horace R.
109 S. Jefferson
Mooresville
Comer, Mrs. C. W.
Comer, Mrs. Kenneth
VanBokkelen, Mrs. Robert
Murphy, Mrs. M. G. Morgantown
Seibel, Mrs. Robert. Nashville

NORTHEASTERN ACADEMY

Albion
Bowman, Mrs. Charles M.
Nash, Mrs. Justin R.
Angola
Barton, Mrs. Robert
Hartman, Mrs. John
Mason, Mrs. Donald G.
Thill, Mrs. Leonard J. Auburn
Rogers, Mrs. E. E. Auburn
Sneary, Mrs. Kenneth D. Avilla
Hathaway, Mrs. Clayton. Butler
Weirich, Mrs. Charles I. Butler
Garrett
Jinnings, Mrs. Loren E.
Kantzer, Mrs. Floyd B.
Reynolds, Mrs. D. Monroe
Reynolds, Mrs. Russel P.

NORTHEASTERN ACADEMY (Continued)

Kendallville

Bryan, Mrs. Robert E.
Gutstein, Mrs. Richard R.
Hardy, Mrs. F. C.
Jinnings, Mrs. Lloyd
Lawson, Mrs. Isaac H.
Messer, Mrs. Frank
Munk, Mrs. Cleorie E.
Seybert, Mrs. Joseph D.
Stallman, Mrs. Earl
Williams, Mrs. Harold O.

Alford, Mrs. James. Hamilton
Wade, Mrs. Alfred A. Howe
Schutt, Mrs. James B. Ligonier
Stultz, Mrs. Quentin F. Ligonier
Webster, Mrs. Paul. Ligonier
Fipp, Mrs. August L. Rome City
Lehman, Mrs. Kenneth. Topeka
Showalter, Mrs. John P. Waterloo
Pulskamp, Mrs. Bertrand
Luckey, Mrs. Robert. Wolf Lake

ORANGE-WASHINGTON COUNTIES

Tower, Mrs. T. Kermit
Sugarman, Mrs. Benj. E.
Colglazier, Mrs. Granville G.

Orleans

Baker, Mrs. Robert E.
Hodgin, Mrs. Phillip T.
Schoolfield, Mrs. Wm. E.

Paoli

Clark, Mrs. Ivan A.
Hammond, Mrs. Keith
Spears, Mrs. John K.
Green, Mrs. Wm. L.

Salem

Apple, Mrs. E. R.
Episcopo, Mrs. A. R.
Gilliatt, Mrs. James P.
Huckleberry, Mrs. Irvin E.
Mitchell, Mrs. J. I.
Paynter, Mrs. L. W.

OWEN-MONROE COUNTIES

Bloomington

Austin, Mrs. Esther. 114 S. Grant
Baxter, Mrs. Neal E. 515 N. Washington
Borland, Mrs. Ray. Moores Pike
Buckingham, Mrs. Richard E. 705 S. Fess
DeMotte, Mrs. Russell A. 904 S. Rose
Estes, Mrs. Ambrose 701 Highland Ave.
Fowler, Mrs. Ross. 709 Anita
Geiger, Mrs. Dillon. N. Fee Lane
Hardtke, Mrs. Eldred F. Hawthorne Dr.
Holland, Mrs. Charles 712 N. Washington
Holland, Mrs. Philip 514 N. College
Karsell, Mrs. Wm. A. 700 Highland
Link, Mrs. William. Anita Ave.
Lyons, Mrs. Robert Smithville Rd.

Marchant, Mrs. Clarence

350 S. College
Pizzo, Mrs. Anthony. 409 S. Swain
Poolitsan, Mrs. George. 619 E. 9th
Quarles, Mrs. E. Bryan

811 S. Woodlawn
Ramsey, Mrs. Hugh. 619 E. 1st
Reed, Mrs. Wm. 1215 Atwater
Reiger, Mrs. Ted. N. Fess Ave.
Rogers, Mrs. Floyd. 804 E. 8th
Ross, Mrs. Ben. Martinsville Rd.
Schell, Mrs. H. D. 801 E. 7th
Sibbitt, Mrs. J. W.

805 S. Henderson
Smith, Mrs. Herschel
Martinsville Rd.

Smith, Mrs. Paul. 812 N. College
Spencer, Mrs. Beaufort. 712 E. 1st
Stangle, Mrs. Wm. 1818 E. 3rd
Taylor, Mrs. Eugene

1040 Maxwell Lane
Topoligus, Mrs. James

603 N. Walnut
Wilson, Mrs. T. L. Nashville Rd.

Brown, Mrs. Fred. Ellettsville
Stouder, Mrs. Charles. Gosport
Mitchell, Mrs. George L.

Smithville

Brown, Mrs. Marcel S.
358 N. Washington, Spencer
Smith, Mrs. F. R.
448 Lovers Lane, Spencer

PARKE-VERMILLION COUNTIES

Clinton

Casebeer, Mrs. P. B. 844 S. 4th
Evans, Mrs. F. J. 1315 S. Main
Gerrish, Mrs. W. D. 125 S. Main
Herzberg, Mrs. Milton. 545 S. 4th
Kercheval, Mrs. J. M. Box 192
Pickett, Mrs. Paul. 427 Whitcomb
White, Mrs. I. D. R. R.

Myers, Mrs. W. C. Dana
Britton, Mrs. W. D. Montezuma
Saunders, Mrs. J. L. Newport
Johnson, Mrs. W. A. Perrysville

Rockville

Bloomer, Mrs. J. R. N. Market
Bloomer, Mrs. R. S. W. York
Dowell, Mrs. E. H. 708 W. Ohio
Harstad, Mrs. C. W. High
Merrell, Mrs. B. M. S. Market
Pirkle, Mrs. H. B. State Sanitorium
Staff, Mrs. R. A. State Sanitorium

PERRY COUNTY

Bush, Mrs. Hargis R.

6th St., Cannellton
Glackman, Mrs. J. C. Rockport
Tell City

Coultas, Mrs. P. J. 809 Main
Dome, Mrs. Hardin S. 704 9th
Dukes, Mrs. David A. 521 Main
Glenn, Mrs. F. C. 436 Main
James, Mrs. N. A. 740 9th
Lally, Mrs. B. V. 622 Main
Lashley, Mrs. D. L. 606 9th
Lohoff, Mrs. Lewis C. 415 14th
Neifert, Mrs. Noel L. 1118 Blum

Snyder, Mrs. E. R. Troy

PORTER COUNTY

Robertson, Mrs. W. C.
600 E. Morgan, Chesterton

Valparaiso

Davis, Mrs. Carl. 202 Indiana
DeGrazia, Mrs. E. J. 157 McIntyre
Eades, Mrs. Ralph C.
501 E. Lincoln Way

PUTNAM COUNTY

Bainbridge

Veach, Mrs. Lester W.
Veach, Mrs. Richard L.

Gray, Mrs. Clyde. Cloverdale
Huckleberry, Mrs. Carl
P. O., Cloverdale

Greencastle

Dettloff, Mrs. Fredrick R.
201 W. Walnut
Dobbs, Mrs. O. D. R. R. 3
Fuson, Mrs. W. J.

108 Northwood Blvd.
Johnson, Mrs. James B.
Highfall Ave.

Rhea, Mrs. Gilbert D.
126 E. Washington
Schauwecker, Mrs. Cleon M.

613 Ridge Ave.
Steele, Mrs. Dick J.
207 Northwood Blvd.

Tennis, Mrs. George T.
602 S. Jackson

Tipton, Mrs. William R.
203 Northwood Blvd.

Wiseman, Mrs. V. Earle. 6 Durham
Gwaltney, Mrs. L. F. Roachdale

RANDOLPH COUNTY

Farmland

Nixon, Mrs. Bryon. N. Main
White, Mrs. Harvey E. S. Main

Lynn

Harmon, Mrs. Wayne
113 W. Church
Jordan, Mrs. Leo E.

209 W. Church
Slick, Mrs. Crystal R.

104 E. Sherman
Potter, Mrs. Richard M.
120 Walnut

Union City

Chambers, Mrs. Leroy B.
800 N. Columbus
Phipps, Mrs. Leland K.

516 N. Howard
Reid, Mrs. Robert W.

706 W. Division
Voisinet, Mrs. R. A. 417 N. Howard
Wills, Jr., Mrs. Benjamin F.

326 N. Columbia

Winchester

Brenner, Mrs. Ivan E. 115 N. East
Dininger, Mrs. W. S. 303 S. Main
Engle, Mrs. Russell B. R. R. 2
Painter, Mrs. Lowell W.

507 S. Main
Sparks, Mrs. Paul W. 601 W. Will

RIPLEY COUNTY

Hisrich, Mrs. L. W. Batesville
Lippoldt, Mrs. C. L. Batesville
Conrad, Mrs. Henry W. Milan
Hunter, Mrs. G. L. Milan
Daley, Mrs. Edward H. Oldenburg
Row, Mrs. George. Osgood
Smith, Mrs. Lee R. Osgood
McConnell, Mrs. William. Sunman
Moran, Mrs. N. D. Versailles

RUSH COUNTY

McNabb, Mrs. George... Carthage
Worth, Mrs. C. Willard.... Milroy

Rushville

Atkins, Mrs. C. C.... 410 N. Perkins
Corpe, Mrs. Kenneth F.... R. R. 4
Denny, Mrs. Melvin.... 124 E. 12th
Ellis, Mrs. Davis.... 719 N. Perkin
Green, Mrs. Charles.... 912 N. Main
Green, Mrs. Frank.... 516 N. Morgan
Hoover, Mrs. Eugene

235½ W. 3rd

Johnson, Mrs. Robert I.

841 N. Harrison

Kennedy, Mrs. R. O.... 1004 N. Main

Kiplinger, Mrs. J. R.... 1301 N. Main

Lee, Mrs. John.... 914 N. Morgan

Nutter, Mrs. W. H.

1003 N. Morgan

Shanks, Mrs. Roy E.

1110 N. Morgan

SHELBY COUNTY

Nigh, Mrs. R. M.... Fairland

Davis, Mrs. John A.... Flat Rock

Jean, Mrs. Thomas A.... Morristown

Miller, Mrs. Frank H.... Morristown

Shelbyville

Barnum, Mrs. Emerson

110 E. Hendricks

Bass, Mrs. F. E.

169 W. Washington

Dalton, Mrs. Wilson L.

401 Sunset Dr.

Gehres, Mrs. Robert W. 610 Shelby

Grove, Mrs. E. G.

242 W. Broadway

Inlow, Mrs. C. Fred

48 E. Mechanic

Inlow, Mrs. Herbert H.

212 N. Harrison

Inlow, Mrs. W. D.... Spring Hill Rd.

McFadden, Mrs. Walter C.

28 W. Mechanic

Miller, Mrs. R. C.... 17 W. Mechanic

Phares, Miss Frances

408 S. Harrison

Richard, Mrs. Norman F.

45 W. Washington

Scott, Mrs. V. B.... R. R. 2

Silbert, Mrs. David B.... 623 S. West

Spindler, Mrs. Robert D.

165 W. Mechanic

Tindall, Mrs. Paul R.

164 W. Franklin

Tindall, Mrs. W. R. 616 S. Harrison

Whitcomb, Mrs. Roger F.

413 W. South

Coulson, Mrs. S. B.... Waldron

ST. JOSEPH COUNTY

Thornton, Mrs. M. J.

R. R. 2, Bremen

Mishawaka

Duvall, Mrs. W. N.... 714 N. Mason

Ganser, Mrs. Richard A.

1020 Wilson Blvd.

Goethals, Mrs. C. J.

602 Lincolnway W.

Martin, Mrs. Charles F. Jr.

2125 Linden

McDonald, Mrs. R. M.

E. Jefferson Rd.

Orr, Mrs. W. Robert

1335 Prospect Dr.

Proudfit, Mrs. C. H.... 1135 E. 3rd

Rosenwasser, Mrs. Jacob

415 Indiana

Sirlin, Mrs. Edward M.

R. R. 19, E. Jefferson Rd.

Spalding, Mrs. Wendell L.

617 Webster

Templeton, Mrs. Ames R.

522 Calhoun

Walerko, Mrs. Frank.... 626 Indiana

Walters, Mrs. Charles E.

111 S. Cedar

Whitlock, Mrs. Francis

304 Lincoln Way E.

Whitlock, Mrs. Merle E. 123 W. 4th

Wurster, Mrs. H. C.... 221 E. 3rd

Wygant, Mrs. M. D.... R. R. 1

Wyland, Mrs. B. J.... 510 Calhoun

Bassler, Mrs. C. R.

R. R. 4, Niles, Mich.

Houser, Mrs. D. S.

R. R. 2, Box 167, North Liberty

Cline, Mrs. Kenneth L.... Wyatt

South Bend**A**

Acker, Mrs. Robert B.

103 S. Ironwood

Arisman, Mrs. R. K. 1615 E. Colfax

B

Balla, Mrs. Morris.... 1516 E. Wayne

Baran, Mrs. Charles.... 128 Tasher

Bechtold, Mrs. S. E.... 313 Pendle

Bennett, Mrs. Jene R.

1072 Woodward

Berke, Mrs. Robt. D.

2510 Erskine Blvd.

Biasini, Mrs. B. A.

149 Glendale Rd.

Bickel, Mrs. David A.

1335 E. Wayne St.

Birmingham, Mrs. P. J.

1126 E. Irvington

Bishop, Mrs. C. A.

1301 Garland Rd.

Bixler, Mrs. Louis C. 1817 Portage

Blackburn, Mrs. Erwin

1343 E. LaSalle

Bodnar, Mrs. Leslie M.... 810 Arch

Bolka, Mrs. B. J.

222 Wildmere Dr.

Borough, Mrs. L. D. 1726 McKinley

Bryan, Mrs. Robert J.

604 E. Ewing

Buchanan, Mrs. Wallace D.

1351 E. South

Buechner, Mrs. Fred W.

603 W. Marion

Bussard, Mrs. C. F.

329 W. Madison

Bussard, Mrs. Frank

1332 E. Monroe

C

Carter, Mrs. F. R. N.

2000 E. Jefferson Blvd.

Clark, Mrs. Stanley A.

1242 E. Jefferson Blvd.

Clark, Mrs. W. H.

1336 E. Wayne, No.

Colip, Mrs. George D.... 300 David

Condit, Mrs. D. H.... 1521 E. Wayne

Cook, Mrs. Gordon C.

1620 Southwood Ave.

Custer, Mrs. Edward W.

1111 Darden Rd.

D

Denham, Mrs. Robert H.

1429 E. Wayne

Dietl, Mrs. Ernest L.

216 S. Coquillard Dr.

Dodd, Mrs. Robert D.... 1917 Kinyon

Dolezal, Mrs. Bernard J.

814 Turnock

Donnelly, Mrs. Everett

R. R. 6, Box 51B, Miami Rd.

Duggan, Mrs. James A.

110 Peashway

Dunlap, Mrs. D. Logan

123 North Shore Dr.

E

Edwards, Mrs. Bernard E.

1341 E. Wayne

Egan, Mrs. Sherman L.

944 Riverside Dr

Ellison, Mrs. Alfred Dragon Trail

English, Mrs. J. Paul.... 1317 Wall

Erickson, Mrs. G. Walter

209 Wildmere Dr.

Erickson, Mrs. L. G.

1212 E. Woodside

F

Faltin, Mrs. L.

302 S. Coquillard Dr.

Feferman, Mrs. Martin

1914 Rockne Dr.

Feldman, Mrs. Max

702 N. Lafayette Blvd.

Firestein, Mrs. Ben Z.

124 N. Eddy

Fish, Mrs. C. M.... 119 Marquette

Fish, Mrs. Edson C.

1264 E. Colfax

Fisher, Mrs. L. F.... 1717 E. Colfax

Frank, Mrs. L. L.

534 N. Lafayette Blvd.

Frash, Mrs. D. W.

1235 E. Wayne, So.

Frey, Mrs. W. B.

617 Northwood Dr.

Friedman, Mrs. Morris S.

1601 E. Cedar

G

Gates, Mrs. George E.

411 W. North Shore Dr.

Gilman, Mrs. Marcus M.

2120 E. Jefferson Blvd.

Giordano, Mrs. A. S.... 1222 25th

Gordersky, Mrs. George

2744 Sampson

Goraczewski, Mrs. T. C.

1016 W. Washington

Green, Mrs. George F.

1515 E. Wayne

Green, Mrs. Norvel E.

1726 E. LaSalle

Grillo, Mrs. Donald. 1832 N. Adams

Grorud, Mrs. Alton C.

129 W. North Shore Dr.

H

Hall, Mrs. James M.

1416 E. Monroe

Hamilton, Mrs. Charles O.

1498 Northern

Harmon, Mrs. V. E.

3221 Mishawaka

Helman, Mrs. Harry W.

120 W. Franklin Pl.

Helmer, Mrs. John.... 1825 Wilbur

Hilbert, Mrs. John W.

410 W. Washington

Hillman, Mrs. Marion W.

1516 Marquette Blvd.

Hyde, Mrs. C. C.... 1521 E. Colfax

ST. JOSEPH COUNTY (South Bend—Continued)

J
Johns, Mrs. N. C. . . . 1329 N. St. Joseph

K
Kamm, Mrs. Bernard . . . 1402 E. Washington
Karn, Mrs. John W. . . . 1444 Sunnymede
Klahr, Mrs. Ellsworth E. . . . 1422 McKinley
Knodel, Mrs. K. T. . . . R. R. 2, Country Club Dr.
Kramer, Mrs. A. A. . . . 1519 Miami
Krueger, Mrs. John E. . . . 1206 N. Lawrence

L
Lane, Mrs. William H. . . . 845 Park
Lang, Mrs. Joseph E. . . . 505 Dixie Hwy., No.
Langenbahn, Mrs. Carl J. . . . 1339 E. South
Lionberger, Mrs. John R. . . . 1224 E. Wayne, No.
Liss, Mrs. Emanuel . . . 1612 E. Madison
Liston, Mrs. Ann . . . 415 St. Joseph Bank Bldg.
Lockhart, Mrs. Philip . . . 409 S. 26th
Ludwick, Mrs. Harry . . . 730 Park

M
McCraley, Mrs. W. J. . . . 2420 Erskine Blvd.
Metcalf, Mrs. G. E. . . . 1209 E. Wayne, No.
Mueller, Mrs. H. M. . . . 3525 Winding Wood Dr.
Murphy, Mrs. Eugene C. . . . 1411 Sunnymede
Murphy, Dr. Josephine . . . 505 W. LaSalle

N-O
Nelson, Mrs. Raymond E. . . . 1909 E. Madison
Olson, Mrs. Kenneth . . . 1228 E. Woodside

P
Pauszek, Mrs. Thomas B. . . . 916 Riverside Dr.
Peltier, Mrs. Hubert . . . 416 Manchester Dr.
Petrass, Mrs. Andrew . . . Liberty Hwy., R. R. 2, Box 47
Plain, Mrs. George . . . 2280 Ponader Dr.
Potter, Mrs. Thomas P. . . . 1902 Marine

Pyle, Mrs. H. Dale . . . 115 N. Sunnyside

R
Rigley, Mrs. Edward L. . . . 2161 Dixie Hwy., No.
Rodin, Mrs. H. H. . . . 1138 E. Wayne, So.
Rosenheimer, Mrs. George M. . . . 1425 E. Woodside
Rubens, Mrs. Eli . . . 1331 E. Victoria
Rudolph, Mrs. Carl . . . 2016 E. Madison

S
Sanderson, Mrs. Robert B. . . . 1331 Sunnymede
Sandock, Mrs. I. . . . 125 W. Marion
Sandock, Mrs. Louis E. . . . 310 S. Sunnyside

Sandoz, Mrs. H. H. . . . 239 S. Hawthorne Dr.
Sandoz, Mrs. Louis A. . . . 304 S. Twyckenham Dr.
Savery, Mrs. Charles E. . . . 1009 E. Jefferson, No. 6
Schiller, Mrs. Herbert A. . . . 1813 E. Cedar
Scott, Mrs. Frank M. . . . 1220 E. Woodside
Selby, Mrs. K. E. . . . 1327 E. Wayne, No.
Sennett, Mrs. C. M. . . . 1129 Belmont
Sensenich, Mrs. R. L. . . . 128 S. Scott
Sharp, Mrs. M. C. . . . 2636 Birchway
Shelley, Mrs. Edward S. . . . 207 S. Taylor
Slominski, Mrs. Harry H. . . . 1862 College
Stiver, Mrs. Dan D. . . . 1329 Belmont
Stratigos, Mrs. Joseph S. . . . 2602 South Bend

T

Thompson, Mrs. John M. . . . 1618 Cedar
Traver, Mrs. P. C. . . . 1010 Riverside Dr.
V-W-Z
Vurpillat, Mrs. F. J. . . . 2102 E. Cedar
Weiss, Mrs. Eugene . . . 2517 S. Michigan
Zeiger, Mrs. Irwin L. . . . 1205 E. Irvington

STARKE-PULASKI COUNTIES

De Naut, Mrs. James Knox
Matthew, Mrs. J. Robert North Judson

Winamac
Carneal, Mrs. Thoman
Halleck, Mrs. Harold J.
McCasky, Mrs. G. H.
Thompson, Mrs. William R.
Yale, Mrs. Charles A.

SULLIVAN COUNTY

Clayton, Mrs. G. W. Carlisle
Deputy, Mrs. F. M. Dugger
Dukes, Mrs. F. M. Dugger
Bland, Mrs. H. E. Fairbanks
O'Dell, Mrs. C. H. Farmersburg
Thrall, Mrs. C. U. Hymera
Wiork, Mrs. H. E. Shelborn

Sullivan
Bedwell, Mrs. Marion 345 W. Washington
Carmeter, Mrs. Harry 509 W. Washington
Crowder, Mrs. J. R. 241 W. Washington
Libpe, Mrs. A. B. 435 W. Washington
Linley, Mrs. S. E. 400 W. Washington
Maple, Mrs. J. B. 116 S. Section
Scott, Mrs. G. D. 409 W. Washington
Scott, Mrs. I. H. 330 W. Washington
Steele, Mrs. J. W. 526 W. Washington
Stratton, Mrs. Harry 112 Cross

TIPTON COUNTY

Cotton, Mrs. Stanley . . . Goldsmith
Dunham, Mrs. Wilbur . . . Kempton
Stouder, Mrs. Albert Kempton

Tipton
Burkhardt, Mrs. B. A. . . 328 N. West
Carter, Mrs. Jean 215 Green
Compton, Mrs. George . . . 315 W. Jefferson
Gossard, Mrs. M. B. . . . 203 N. West
Kurtz, Mrs. William A. . . . R. R. 1
Overman, Mrs. F. V. . . . 222 W. Jefferson
Warne, Mrs. George . . . 210 N. West

Tranter, Mrs. Wm. F. . . . Sharpsville
Moser, Mrs. E. B. Windfall
Ericson, Mrs. Lorene Windfall

TIPPECANOE COUNTY

Derhammer, Mrs. G. L. . . . Brookston
Gish, Mrs. H. M. Brookston

Lafayette
Arnett, Mrs. A. C. 516 S. 7th
Bailey, Mrs. R. D. 725 S. 11th
Clauser, Mrs. Mary S. . . . 2020 Union
Dubois, Mrs. Ramon 519 Calvert Lane
Flack, Mrs. R. A. 627 Central
Frey, Mrs. Harley 927 Highland
Graham, Mrs. Thomas 1213 Wea
Gripe, Mrs. Richard 1623 S. 5th
Harter, Mrs. Eli B. 918 King
Hunsberger, Mrs. W. Glenn . . . 506 S. 7th
Johnson, Mrs. Herbert . . . 1405 S. 5th
Jones, Mrs. David 2055 S. 9th
Karberg, Mrs. Richard J. . . . 1600 Potomac
Klepinger, Mrs. Harry E. . . . 909 N. 21st
McAdams, Mrs. Hugh 1411 Sunset Dr.
McClelland, Mrs. D. C. . . . 1021 Highland
Morrison, Mrs. J. S. 422 N. 7th
Neumann, Mrs. Kenneth 1410 S. 18th
Pyke, Mrs. Inez 532 S. 9th
Ratcliff, Mrs. Frank W. . . . 1000 Wea
Rogers, Mrs. J. G. 1203 S. 14th
Rothrock, Mrs. Philip 2061 S. 9th
Sholty, Mrs. William R. R. 8, Shadeland Farm Rd.
Trout, Mrs. Carl J. 800 State
VanReed, Mrs. Earl 802 S. 9th
Vermilya, Mrs. R. W. 1215 King

West Lafayette
Bayley, Mrs. William 622 Rose
Beeler, Mrs. J. Moss Box 308, Wabash Valley San.
Burkle, Mrs. John C. 121 University
Eaton, Mrs. M. J. 425 Forrest Hill Dr.
Engeler, Mrs. James E. . . . 1316 N. Grant
Ferguson, Mrs. William B. . . . 420 Forrest Hill Dr.
Gery, Mrs. R. D. 306 Park
Harden, Mrs. Murray 610 Carrolton Blvd.
Holladay, Mrs. L. J. 227 S. Salisbury
Hughes, Mrs. Richard R. . . . 908 Carrolton Blvd

TIPPECANOE COUNTY
(Lafayette—Continued)

Johnson, Mrs. Lowell . . . 492 Maple
 Klatch, Mrs. Ben Z. . . 1504 N. Grant
 McFadden, Mrs. James
 1424 N. Salisbury
 Miller, Mrs. Roland
 600 Ridgewood Dr.
 Peyton, Mrs. Frank W.
 612 Ridgewood Dr.
 Schuck, Dr. Cecilia . . . 402½ Waldron
 Stahl, Mrs. E. T. . . . 324 Park Lane
 Spurlock, Mrs. F. H. . . . 914 Vine
 Van Buskirk, Mrs. E. L.
 1301 Ravinia Rd.
 Washburn, Mrs. W. W.
 209 Forest Hill Dr.

Houser, Mrs. Wayne W. . . . Monon
 McClure, Mrs. S. F. . . . Monon
 Mayfield, Mrs. C. H. . . . Reynolds
 Mitchell, Mrs. E. T. . . . Romney
 Babb, Mrs. Forest T. . . . Stockwell

VANDERBURGH COUNTY

Purcell, Mrs. Jack
 R. R. 5, Boonville
 Stover, Mrs. Wendell C. Boonville
 Evansville

A
 Acre, Mrs. Robert R. . . 2311 Lincoln
 Adler, Mrs. Ray N. . . 1660 Lincoln
 Allenbaugh, Mrs. A. E.
 3218 E. Mulberry
 Antes, Mrs. Earl H.
 1201 Bonnieview Dr.
 Austin, Mrs. Eugene W.
 2163 Bayard Pk. Dr.

B
 Baker, Mrs. J. S.
 2670 Stringtown Rd.
 Baker, Mrs. Mason
 1428 Lant Circle
 Barclay, Mrs. I. C. . . 1215 Parrett
 Barnhart, Mrs. Willard T.
 507 Boeke Rd.
 Bennett, Mrs. Abner P.
 961 Blue Ridge Rd.
 Bissonette, Mrs. Roger P.
 3108 E. Walnut
 Brockmole, Mrs. Arnold W.
 700 Mary
 Bryan, Mrs. Stanton L.
 3211 E. Mulberry
 Buehner, Mrs. Donald
 1543 McArthur Circle
 Buchholz, Mrs. Ransom R.
 1023 Taylor

Buikstra, Mrs. C. R.
 Darmstadt Rd.
 Burnikel, Mrs. Ray H.
 960 S. Rotherwood Ave.

C
 Cacia, Mrs. John J.
 420 S. Boeke Rd.
 Caldwell, Mrs. William C.
 643 College Hwy.
 Clements, Mrs. A. F. . . 3315 Lincoln
 Clouse, Mrs. Paul A.
 2066 Bayard Pk. Dr.
 Cockrum, Mrs. William M.
 1414 Parkside Dr.
 Coleman, Mrs. Joseph E.
 1725 Sweetzer
 Combs, Mrs. Herman
 R. R. 1, Box 561
 Combs, Mrs. P. B. . . . 4109 Lincoln

Corcoran, Mrs. P. J. V.
 2412 E. Chandler
 Crane, Mrs. A. L. . . . Kratzville Rd.
 Crawford, Mrs. James
 2713 N. Shore Dr.
 Crevello, Mrs. Albert J.
 1664 Lincoln
 Crimm, Mrs. Paul D.
 Boehne Hospital
 Cullnane, Mrs. Chris W.
 3020 Mt. Vernon Rd.
 D
 Daves, Mrs. W. Lawrence
 708 College Hwy.
 Deems, Mrs. Myers
 741 Bayard Pk. Dr.
 Denzer, Mrs. Edward K.
 Outer Lincoln Ave.
 Denzer, Mrs. W. O. . . 923 Bellemeade
 Dieckman, Mrs. Herbert S.
 Harrelton Court

Dodd, Mrs. R. K.
 New Green River Rd.
 Dycus, Mrs. Walter A.
 Koring Rd.
 Dyer, Mrs. Wallace K.
 812 St. James
 Dyer, Mrs. Wallace K. Sr.
 602 S. E. Riverside Dr.

E
 Ehrich, Mrs. William S.
 1500 S. Kentucky
 Eisterhold, Mrs. John A.
 Koring Rd.
 Engel, Mrs. Edgar L.
 1411 E. Park Dr.

F
 Faul, Mrs. Henry . . . 725 S. Willow Rd.
 Fenneman, Mrs. Robert J.
 851 Lincoln
 Fisher, Mrs. William C.
 1319 S. Kentucky
 FitzGerald, Mrs. Maurice D.
 924 Bayard Pk. Dr.
 Fitzsimmons, Mrs. E. L.
 500 S. Boeke Rd.
 French, Mrs. William G.
 844 Hoosier

G
 Garland, Mrs. E. A. . . . Plaza Dr.
 Gaul, Mrs. L. Edward
 508 S. Boeke Rd.
 Getty, Mrs. William
 1009 N. Spring
 Griep, Mrs. Arthur H.
 5414 Madison

H
 Hammond, Mrs. R. Case
 1221 Ravenswood Dr.
 Hare, Mrs. Daniel M. . . 2112 Lincoln
 Hart, Mrs. Paul . . . 1436 Lincoln
 Hartley, Mrs. C. A. Jr.
 1300 S. Kentucky
 Healy, Mrs. William F.
 722 S. Willow Rd.
 Hefti, Mrs. Karl . . . Hezmer Rd.
 Heinrich, Mrs. Weston
 2012 E. Chandler
 Helper, Mrs. Morton
 458 Ruston Ave.
 Hermayer, Mrs. Stephen
 1303 St. James Blvd.
 Herrmann, Mrs. Gordon T.
 3109 E. Oak
 Herzer, Mrs. C. C.
 2020 E. Mulberry
 Huggins, Mrs. Victor . . 520 S. Alvord

J-K
 Johnson, Mrs. Stephen L.
 2215 Lincoln
 Kessler, Mrs. R. B. . . 1003 First Ave.
 Kiechle, Mrs. Frederick L.
 Boehne Hospital
 Kleindorfer, Mrs. R. L.
 615 S. Willow Rd.

L
 Laubscher, Mrs. Clarence
 Kratzville Rd.
 Lawrence, Mrs. Joseph C.
 1362 E. Chandler
 Leich, Mrs. Charles F.
 306 S. E. Riverside Dr.
 Leslie, Mrs. Ernil T.
 517 S. E. First
 Logan, Mrs. J. R. . . . 503 First Ave.

M
 Macer, Mrs. Clarence
 3800 W. Pennsylvania
 MacKenzie, Mrs. Pierce
 907 E. Gum
 McCool, Mrs. J. H.
 920 E. Mulberry

McDonald, Mrs. J. D. . . 4300 Lincoln
 McKaffy, Mrs. John
 920 Bayard Park Dr.
 Mehl, Mrs. Rudolph
 3103 Bellemeade
 Meyer, Mrs. Keith
 399 S. Alvord Blvd.
 Miller, Mrs. L. B. . . . 501 Scenic Dr.
 Miller, Mrs. Milton
 8123 Newburgh Rd.
 Miller, Mrs. Robert J. . . Plaza Dr.
 Mills, Mrs. Fred . . . 555 S. Kelsey
 Mino, Mrs. Raymond
 1700 Bayard Pk. Dr.

Mino, Mrs. Robert
 2777 Wayside Dr.
 Moehlenkamp, Mrs. Charles
 305 E. Iowa
 Murphy, Mrs. Edward U.
 7 W. Buena Vista Rd.

N
 Neucks, Mrs. H. C.
 235 Knickerbocker Circle,
 Hampton, Va.
 Newman, Mrs. Alvin E.
 Harrelton Court
 Niedermayer, Mrs. Alfred
 815 College Hwy.
 Nonte, Mrs. Lee . . . 1041 Taylor

P
 Pastor, Mrs. J. W. . . . 5206 Lincoln
 Pollard, Mrs. Walter
 1230 S. E. 2nd
 Porro, Mrs. Francis . . 909 Villa Dr.
 Present, Mrs. Julian
 201 Parker Dr.
 Pugh, Mrs. Willis . . . 5204 Lincoln

R
 Ratcliffe, Mrs. A. W.
 501 S. E. First
 Ravdin, Mrs. Bernard . . 706 Sunset
 Ravdin, Mrs. Marcus . . 2025 Lincoln
 Reich, Mrs. Clarence
 1209 N. Fulton
 Richey, Mrs. Clifford . . 407 Congress
 Rininger, Mrs. Harold . . 2154 E. Gum
 Ritchie, Mrs. William . . Feltman Dr.
 Ritz, Mrs. Albert . . . 1375 E. Chandler
 Rosenblatt, Mrs. Bernard
 626 St. James

VANDEBURGH COUNTY (Evansville—Continued)

Ruddick, Mrs. H. C.
845 Ravenswood Dr.
Rusche, Mrs. Henry J. 315 W. Iowa
Russell, Mrs. Richard 2516 Adams

S
Schaefer, Mrs. William C.
3118 E. Powell
Schirmer, Mrs. Robert H.
2710 Hartmetz
Schneider, Mrs. Charles P.
2924 W. Maryland
Schriefer, Mrs. V. V. 390 S. Alvord
Slaughter, Mrs. Howard
800 St. James
Slaughter, Mrs. John
622 College Hwy.
Springstun, Mrs. W. Russel
854 Lodge
Stanton, Mrs. Harmon L.
701 College Hwy.
Steele, Mrs. Paul W.
1906 Bellemeade
Sterne, Mrs. John H. 741 E. Powell
Stork, Mrs. Urban 414 S. Kelsey
Strueh, Mrs. Paul 1100 Harrelton Court

T
Tager, Mrs. S. H. 900 E. Mulberry
Tweedall, Mrs. Daniel C.
Mt. Pleasant Rd.
Tweedall, Mrs. D. G.
2202 W. Illinois

V-W
Visher, Mrs. John W.
Mt. Pleasant Rd., R. R. 5
Weiss, Mrs. H. G. 1014 E. Powell
Welborn, Mrs. Mell B. Mt. Auburn
Wilhelmus, Mrs. C. Kenneth
Newburgh Rd.
Wilhelmus, Mrs. Gilbert M.
915 S. Weinbach
Willison, Mrs. George W.
411 Lincoln Pk. Dr.
Wilson, Mrs. John D.
1207 E. Park Dr.
Wilson, Mrs. Ralph 2317 E. Gum
Wishart, Mrs. Shelby
1105 S. E. First St.
Wynn, Mrs. J. F. 651 S. Weinbach

Y-Z
Young, Mrs. C. Curtis Jr.
851 E. Gum
Zimmerman, Mrs. Harold
Boeke Rd.

Oliphant, Mrs. Frank Mt. Vernon
Durkee, Mrs. Melvin S. Newburgh
Faith, Mrs. Ira L. Newburgh
Zwickel, Mrs. R. E. Newburgh
Ropp, Mrs. Harold New Harmony
Boren, Mrs. Paul Poseyville
Lang, Mrs. Shirley C. Rockport
Wilhelmus, Mrs. W. M. St. Wendell

VIGO COUNTY

La Bier, Mrs. C. R.
Lena Lake, Brazil
Gerrish, Mrs. Don A.
North Terre Haute
McIntosh, Mrs. Wilbert Riley
Terre Haute

A
Agee, Mrs. Ernest 228 S. 21st
Allen, Mrs. O. T. 32 S. 20th

Anderson, Mrs. W. C. 380 S. 22nd
Ault, Mrs. Roy J. 926 Barton Ave.

B
Baldrige, Mrs. Ezra 1435 S. 6th
Baldrige, Mrs. William O.
2500 N. 9th
Blum, Mrs. Leon L. 1101 S. 6th
Bopp, Mrs. Henry W. 132 Barton
Bopp, Jr., Mrs. Henry W.
2237 Poplar
Bopp, Mrs. James 2635 Wilson Dr.
Brown, Mrs. Robert 2544 N. 9th

C-D
Ca Jacob, Mrs. Melville 1000 S. 6th
Caldwell, Mrs. M. V. R. R. 7
Carpenter, Mrs. Geo. C. R. R. 5
Combs, Mrs. Charles 2516 N. 9th
Combs, Mrs. Stuart 2620 N. 10th
Conklin, Mrs. James 127 Adams
Curry, Mrs. C. A. 1402 S. 17th
Decker, Mrs. Harvey R. R. 3
Dyer, Mrs. G. Wallace
2710 Wilson Dr.

F
Forsyth, Mrs. D. H. 714 S. 8th
Freed, Mrs. John E. 2408 N. 10th
Freed, Mrs. John, Jr.
720 Collett Ave.
Fuqua, Mrs. H. B. 2303 N. 9th

G
Gilbert, Mrs. Ivan 2641 Crawford
Goodman, Mrs. Hubert T.
328 Potomac
Gossom, Mrs. Donn R. 1914 Ohio

H
Haslem, Mrs. Ezra 205 Potomac
Haslem, Mrs. Jack R. 2144 Poplar
Humphrey, Mrs. Paul 2631 N. 9th

K-L
Kabel, Mrs. Robt. N. 3318 Oak
LaBier, Mrs. Russell
21 McKinley Blvd.
Lancet, Mrs. Robert O.
Deming Woods, R. R. 5
Loewenstein, Mrs. Werner
1421 S. 7th
Luckett, Mrs. C. L. R. R. 2

M
McBride, Mrs. Noel S.
Allendale, R. R. 2
McCarthy, Mrs. Frank 926 S. 6th
McEwen, Mrs. James W.
R. R. 5, Robinwood
Mahoney, Mrs. C. L. R. R. 3
Malone, Mrs. L. A. 342 S. 22nd
Mason, Mrs. Lester
R. R. 5, Robinwood
Mattox, Mrs. Don A.
Deming Woods, R. R. 5
Mattox, Mrs. Ernest
Deming Woods, R. R. 5
Meyn, Mrs. W. P. 2101 S. 9th
Miklozek, Mrs. J. E. R. R. 5
Miller, Mrs. D. B. 903 S. 7th
Musselman, Mrs. Glenn R. R. 5

N-O-P
Nay, Mrs. Ernest 29 S. 20th
Neudorff, Mrs. L. G. 113 S. 19th
Oliphant, Mrs. Robert 900½ S. 5th
Pearce, Mrs. Roy V. 1506 S. 6th
Pierce, Mrs. H. J. 1514 S. Center

R
Reed, Mrs. Robert C. 1438 S. 6th
Reynolds, Mrs. R. J. 2126 College
Richart, Mrs. James V.
Deming Woods, R. R. 5

Riggs, Mrs. Floyd 137 S. 24th
Rubin, Mrs. M. M. 2401 Ohio

S
Sayers, Mrs. Frank E.
R. R. 5, Robinwood
Scherb, Mrs. Burton E. 422 S. 25th
Schumaker, Mrs. Robt. A. R. R. 4
Shaffer, Mrs. James S.
2200 3rd Ave.
Showalter, Mrs. John R.
2638 N. 8th
Siebenmorgen, Mrs. Louis
1200 S. 8th
Siebenmorgen, Mrs. Paul
2515 N. 7th
Silverman, Mrs. Norman
1220 S. 8th
Solomon, Mrs. Robert,
213 Barton Ave.
Spigler, Mrs. James 1436 S. 6th
Stoelting, Mrs. J. L. 1919 N. 7th
Sullivan, Mrs. John M.
2242 College

T-V
Topping, Mrs. Malachi,
152 Monterey
Van Arsdall, Mrs. C. R.,
2229 Crawford
Voges, Mrs. Ed. C. 137 S. 20th

W-Z
Weber, Mrs. Joseph 2121 N. 11th
White, Mrs. James V.
1227 S. 6th
Wiedemann, Mrs. Frank E.
1530 S. 6th
Young, Mrs. Rodolph 1115 S. 6th
Zwerner, Mrs. Paul F. 712 Collett

WAYNE-UNION COUNTIES

Kenyon, Mrs. Emil
303 Mulberry, Cambridge City
Barton, Mrs. William M.
North Morton, Centerville
Hutchinson, Mrs. Don
Fountain City
Lewis, Mrs. Frank Liberty

Richmond
Adney, Mrs. Frank, 34 DeBolt Lane
Ake, Mrs. Loren 1707 E. Main
Allen, Mrs. Robert 25 S. 21st
Ballenger, Mrs. Wm. E. 301 S. 20th
Buche, Mrs. Frederick P.
2408 S. "E"
Campbell, Mrs. Perry Cart Rd.
Coble, Mrs. Frank Liberty Pike
Cook, Mrs. Norman 333 S. 15th
Daggy, Mrs. James 1711½ S. "E"
Dingle, Mrs. Paul 415 S. 15th
Ebbinghouse, Mrs. Tom
Spring Grove Heights
Griffis, Mrs. V. C. 210 S. 23rd
Herring, Mrs. George N.
Richmond State Hosp.
Hoffman, Mrs. Curt 204 S. 21st
Holland, Mrs. E. E. 1907 E. Main
Hufnagel, Mrs. C. J. 436 S. 12th
Hunt, Mrs. Gayle 425 S. 19th
Johnson, Mrs. George 338 SW 15th
Johnson, Mrs. Paul 200 S. 18th
Kime, Mrs. Charles 501 S. 19th
Laird, Mrs. Leslie
Richmond State Hospital
Lee, Mrs. Glenn Ward 404 S. 15th
Ling, Mrs. John 339 SW 16th
Logan, Mrs. James Z. 164 S. 20th
Loomis, Mrs. Charles
1105 N. Dr., Berry Field

WAYNE-UNION COUNTIES
(Richmond—Continued)

Mader, Mrs. John Chester Pike
Malcolm, Mrs. Russell
 901 NW "B"
Meredith, Mrs. Elwood . 200 S. 20th
Ramsdell, Mrs. Glenn
 1020 Peacock Rd.
Ross, Mrs. Harry 220 S. 19th
Ross, Mrs. James 321 S. 14th
Runge, Mrs. Paul 115 S. 17th
Sage, Mrs. Charles 48 S. 11th
Shields, Mrs. Tom 47½ S. 11th
Snyder, Mrs. Morris . . 125 S. 20th
Stamper, Mrs. L. Allen . 420 S. 22nd
Stepleton, Mrs. John
 1120 Central Dr.
Stillwell, Mrs. William
 21½ S. 8th
Sweet, Mrs. Howard . . . 20 S. 22nd
Vance, Mrs. Wm. 200 S. 21st
Wanninger, Mrs. Horace
 315 S. 15th
Warrick, Mrs. Francis,
 22 DeBolt Lane
Wertenberger, Mrs. Morris
 115 S. 16th
Whallon, Mrs. Arthur . . 29 S. 10th

Williams, Mrs. Paul
 Richmond State Hospital
Wisener, Mrs. Guthrie . 401 S. 18th

WELLS COUNTY
Bluffton

Annis, Mrs. Homer B. 225 W. Central
Aucreman, Mrs. Charles J. 314 W. South
Caylor, Mrs. Charles E. 114 S. Williams
Caylor, Mrs. Harold D. 411 W. Market
Caylor, Mrs. Truman E. Box 264
Cook, Mrs. Robert G. R.R. 3, Box 44
DeVoe, Mrs. Kenneth
Dorrance, Mrs. Thomas O. 218 W. Central
Eisaman, Mrs. Jack L. 427 W. Wiley
Huber, Mrs. Robert 916 S. Marion
Jackson, Mrs. Charles E. Box 125
Johnston, Mrs. Robert L. 811 S. Morgan
Kephart, Mrs. Bruce R. R. 3, Box 12

Mitchell, Mrs. G. S. . . . 814½ S. Main
Shively, Mrs. John A. 211 Washington
Smith, Mrs. H. Brooks 333 S. Wayne
Talbert, Mrs. Pierre C. 320 S. Main
Tirman, Mrs. Wallace Box 174
Yoder, Mrs. Richard P. S. Wayne

WHITLEY COUNTY

Minick, Mrs. L. J. Churubusco
 Columbia City
Hamilton, Mrs. Thomas G. 416 W. Market
Heritier, Mrs. C. Jules 410 E. Van Buren
Kratz, Mrs. Paul E.
Langohr, Mrs. John L. . 321 N. Main
Lehmberg, Mrs. Otto F. West Park Dr.
Nolt, Mrs. E. V. Westwood Park
Pence, Mrs. Benj. F. N. Chauncey
Thompson, Mrs. Frank 531 E. Van Buren
 South Whitley
Garber, Mrs. Paul A.
Huffman, Mrs. Park

MEMBERS-AT-LARGE

Dale, Mrs. Joseph W. Chesterton
Stephens, Mrs. Lowell R.
 Covington
Walker, Mrs. James L. LaFontaine

Carlyle, Mrs. Ivan E. Michigantown
Balsbaugh, Mrs. George K. North Manchester
Bounell, Mrs. Emery G. Oklahoma City (Okla.)

Omstead, Mrs. M. H. Petersburg
Boren, Mrs. Paul R. Poseyville
McClain, Mrs. Marvin L. Scottsburg
Briggs, Mrs. Carl F. Sullivan
Dierdorf, Mrs. Fred W. Winslow

CONSTITUTION AND BY-LAWS OF THE INDIANA STATE MEDICAL ASSOCIATION

CONSTITUTION

ARTICLE I.—NAME OF THE ASSOCIATION

The name and title of this organization shall be the Indiana State Medical Association.

ARTICLE II.—PURPOSES OF THE ASSOCIATION

The purposes of this Association shall be to federate and bring into one compact organization the medical profession of the State of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to protect its members against imposition; and to enlighten and direct public opinion in regard to the great problems of medical care, and public health, so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

ARTICLE III.—COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Association.

ARTICLE IV.—COMPOSITION OF THE ASSOCIATION

Section 1.—This Association shall consist of Active Members, Associate Members, Senior Members and Honorary Members.

Sec. 2.—*Active Members*.—The active members of this Association shall be the members of the component county medical societies, and no county medical society shall grant membership therein on a basis that does not include membership in the Indiana State Medical Association.

Sec. 3.—*Associate Members*.—Members of the Indiana State Dental Association in good standing are, by virtue of their membership therein, made associate members of the Indiana State Medical Association.

Sec. 4.—*Senior Members*.—Senior members shall be physicians of the State of Indiana who have attained the age of seventy-five years and have held membership in the Indiana State Medical Association for twenty years or more, and who, upon their application, have been certified to the executive secretary as eligible for such membership by the county societies of which they are members.

All members who, previous to the adoption of this amendment to the constitution, were certified as honorary members on the basis of the above qualifications, shall hereafter be classified as senior members.

Sec. 5.—*Honorary Members*.—Honorary members shall consist of teachers, scientists and others who have rendered highly meritorious service to the profession of medicine, and of physicians and surgeons of distinction, upon whom the Association may, through vote of the House of Delegates, desire to confer such membership as a special honor.

Sec. 6.—*Rights and Privileges of Members*.—Active members and senior members shall have the same rights and privileges except as follows:

a. Senior members shall not be required to pay membership dues in the State Association.

b. If senior members desire to receive THE JOURNAL of the State Association, they shall pay the regular subscription price therefor.

c. Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold office. They shall not be required to pay membership dues in the State Association.

ARTICLE V.—HOUSE OF DELEGATES

The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) Delegates elected by the component county societies; (2) the Councilors; and (3) the ex-presidents of the Indiana State Medical Association. The following shall be *ex officio* members: the President, the President-elect, the Executive Secretary, the Treasurer of this Association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President or person presiding shall cast the deciding vote.

ARTICLE VI.—COUNCIL

The Council shall consist of (1) the Councilors, and (2) *ex officio* the President, President-elect, and Treasurer. Besides its duties mentioned in the By-Laws, it shall constitute the Board of Trustees of this organization, having full charge and control of all the property of the Association. It shall have full authority and power of the House of Delegates between sessions of the House of Delegates, except that it shall not make changes in the laws governing the Association nor exercise legislative functions, except as stated in the By-Laws, and at all times shall be the finance committee of the Association. Seven Councilors shall constitute a quorum.

ARTICLE VII.—SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections; and for the organiza-

tion of such Councilor District Societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies. Councilor districts shall be defined by the House of Delegates.

ARTICLE VIII.—CONVENTION AND MEETINGS

Section 1.—The Association shall hold an Annual Convention during which there shall be held such general and section meetings as the Association through its duly constituted officers and committees may provide for.

Sec. 2.—The House of Delegates shall select the place two years in advance for holding the annual convention. The time for the convention shall be fixed by the Council, and the Council shall have the power also to change the place for holding the convention where conditions may create difficulties in holding a successful convention at the place designated by the House of Delegates.

Sec. 3.—Special meetings of either the Association or the House of Delegates shall be called by the President on petition of twenty delegates or fifty members.

ARTICLE IX.—OFFICERS

Section 1.—The officers of this Association shall be a President, a President-elect, an Executive Secretary, a Treasurer, and thirteen Councilors, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member.

Sec. 2.—The officers, except the Councilors and the Executive Secretary, whose election has been provided for hereinafter, shall be elected annually. The terms of elected Councilors shall be for three years and approximately one-third of the number shall be elected annually. All of these officers shall serve until their successors are elected and installed. Provided, that if any elected Councilor fails, without reason acceptable to the Council, in any one calendar year to attend a majority of the meetings of the Council, he shall thereby cease to be a Councilor, and the Executive Secretary shall thereupon take action in accordance with Section 4 of this article.

Sec. 3.—The officers of this Association with the exception of the Executive Secretary shall be elected by the House of Delegates as the first order of business of the last day of the Annual Convention, and no person shall be elected to any such office who is not in attendance on that Annual Convention and who has not been a member of the Association for the preceding two years.

Sec. 4.—The Councilors shall be elected by the respective district societies. If any district fails to meet and elect its Councilor by the time of expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause

a special meeting to be called by said district society for the purpose of such election.

Sec. 5.—Each Councilor district shall elect an alternate Councilor whose term of office shall be the same as the Councilor, namely three years. The alternate Councilor shall be elected in a year during which there is no Councilor elected.

The duties of the alternate Councilor shall be:

1. To represent the Councilor district in the absence of the regularly elected Councilor.

2. To vote only in the absence of the regularly elected Councilor either in the House of Delegates or in Council meetings where he represents the regularly elected Councilor.

3. The alternate Councilor shall not have the power of discussion if the regularly elected Councilor is present.

Sec. 6.—Any officer may be removed from office after a hearing before the Council, on thirty days' notice, on charges in writing, upon a vote of three-fourths of the members of the Council.

Sec. 7.—In event of the death, resignation, removal, or disability of the President, the President-elect shall succeed to the presidency. In the event of the death, disability, resignation or removal of both the President and the President-elect, the chairman of the Council shall become President pro tem and as such shall, within a period of sixty days, call a special session of the members of the House of Delegates for the purpose of electing members to fill these vacancies, who shall serve until the next regular meeting of the House of Delegates, at which time both a President and a President-elect shall be elected, both of whom shall take office immediately upon their election.

Sec. 8.—A vacancy in the office of Treasurer shall be filled by an election by the Councilors at the next regular meeting of the Council following the occurrence of such vacancy.

Sec. 9.—None of the officers shall receive compensation except the Executive Secretary, who shall be employed by the Council, and the Council shall fill any vacancy in that office.

ARTICLE X.—RECIPROCITY OF MEMBERSHIP WITH OTHER STATE SOCIETIES

In order to broaden professional fellowship, this Association is ready to arrange with other State Medical Associations for an interchange of certificates of membership so that members moving from one state to another may avoid the formality of re-election.

ARTICLE XI.—INCOME AND EXPENSES

Funds for carrying on the activities of this Association shall be raised by the following means:

a. Membership dues to be collected by the component county societies in connection with the dues for such component societies. The amount of the dues of each component society shall be fixed by the society itself; and the amount of dues for this Association shall be fixed from time to time by the House of Delegates.

b. Voluntary contributions.

c. Revenues derived from the Association's publications.

d. Any other manner approved by the House of Delegates.

Funds may be appropriated by the House of Delegates to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All motions and resolutions appropriating funds must be referred to the Council for approval before final action is taken thereon.

ARTICLE XII.—REFERENDUM

Section 1.—A General Meeting of the Association may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such question to the members of the Association, who may vote by mail or in person, and if the members voting shall comprise a majority of all the members of the Association, a majority of such vote shall determine the question and be binding on the House of Delegates.

Sec. 2.—The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

ARTICLE XIII.—THE SEAL

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

ARTICLE XIV.—AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any Annual Convention, provided that such amendment shall have been presented in open meeting at the previous Annual Convention, and that it shall have been published twice during the year in *THE JOURNAL* of this Association.

BY-LAWS

CHAPTER I.—MEMBERSHIP

Section 1.—The term "Member" as used in these By-Laws unless otherwise indicated shall mean both active and senior members.

Sec. 2.—Any physician who is a member in good standing of a component county society and

who has paid to this Association his annual dues is a member in good standing of the Indiana State Medical Association, provided, however, that he is a citizen of the United States of America, or has filed his declaration of intention of becoming a citizen and his first citizenship papers are in full force and effect.

Sec. 3.—No person who is under sentence of suspension or expulsion from a component society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association, nor shall he be permitted to take part in any of its proceedings until he has been relieved of such disability.

Sec. 4.—Each member in attendance at the Annual Convention shall register by indicating the component society of which he is a member. When his right to membership has been verified, by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right to all the privileges of membership at that convention. No member shall take part in any of the proceedings of an Annual Convention until he has complied with the provisions of this section.

CHAPTER II.—GENERAL MEETINGS

Section 1.—General Meetings shall mean all meetings planned for attendance by all registered members, and shall include those meetings in which guests of registered members or the general public are also invited. The address of the President shall be delivered in a General Meeting, and the programs of General Meetings shall be arranged by the Executive Committee except where scientific papers are included, in which event the scientific part of the program shall be arranged by the Committee on Scientific Work, with the sanction and approval of the officers.

Sec. 2.—The General or Section Meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and public.

Sec. 3.—All scientific papers read before the Association or any of the sections shall become its property and shall not be published in any but the official publications of this Association, except by consent of the officers and the Editorial Board of this Association. Each such paper shall be deposited with the Executive Secretary when read.

Sec. 4.—The Council shall appropriate from the funds of the Association for each Annual Convention, for the entertainment of its members and guests, such an amount as in the discretion of the Council shall be reasonably needed for that purpose, and no commitments shall be made for expenses in excess of the amount appropriated for such convention. The entertainment funds so appropriated shall be expended at the direction

of the Committee on Convention Arrangements, appointed by the President for the convention for which the appropriation is made. All money in excess of that expended for actual expenses incurred shall revert each year to the treasury of the State Association.

CHAPTER III.—SECTIONS

Section 1.—During the Annual Convention the Association in addition to the general meetings may hold the following section meetings:

- a. Surgical.
- b. Medical.
- c. Eye, Ear, Nose, and Throat.
- d. Anesthesia.
- e. General Practice.
- f. Obstetrics and Gynecology.
- g. Preventive Medicine and Public Health.
- h. Any other sections that hereafter may be provided for by the House of Delegates.

Sec. 2.—The officers of each section shall be a Chairman, a Vice-Chairman, and a Secretary, and they shall preside over the meetings of the sections and shall be responsible to the Committee on Scientific Work for the section speakers and papers.

Sec. 3.—The election of officers of the sections shall be the last order of business of the last meeting of the sections during the Annual Convention.

Sec. 4.—No section meeting shall be allowed to conflict with a general meeting.

CHAPTER IV.—HOUSE OF DELEGATES

Section 1.—The House of Delegates shall meet the day before or during that fixed as the first day of the scientific meeting of the Annual Convention. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as possible with the General or Section Meetings. It shall meet on the last day of the Annual Convention for the election of officers for the ensuing year, and for the completion of any business previously introduced. The order of business shall be arranged as a separate section of the program.

Sec. 2.—Each component county society shall be entitled to send to the House of Delegates each year one delegate for every fifty members and one for each major fraction thereof; but, irrespective of the number of members, each component society which has made its annual report and paid its assessments, as provided in this Constitution and By-Laws, shall be entitled to one delegate, except that where a component society is made up of physicians of more than one county,

each county shall be entitled to at least one delegate to be selected by the physicians residing in such county.

The names of duly elected delegates and alternates from each component society shall be sent to the Executive Secretary of this Association annually on or before December first prior to the Annual Convention at which such delegates are to serve. No one shall be entitled to a seat in the House of Delegates unless his credentials as a delegate or alternate, properly signed by the secretary of his county society, be presented to the Committee on Credentials at the time of the Annual Convention.

Sec. 3.—Fifty delegates shall constitute a quorum.

Sec. 4.—The House of Delegates shall:

a. Elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

b. Divide the State into Councilor Districts, specifying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each district a medical society, and all members of component county societies, and no others, shall be members of such district societies.

c. Have authority to appoint committees for special purposes from among members of the Association who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and the members of such committees may be present and participate in the debate on their reports.

d. Approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Sec. 5. — Funds may be appropriated by the House of Delegates, subject to approval by the Council, for such purposes as will promote the welfare of the Association and the profession.

Sec. 6.—At the first meeting the President shall announce the membership of the reference committees, as hereinafter provided for, and any other committees considered by him necessary to expedite the business of the Association.

Sec. 7.—In addition to the meetings provided for in Section 1 of this Chapter IV, a meeting of the House of Delegates shall be held each year as nearly as is conveniently possible, six months after the last meeting provided for in said Section 1. The date and place of this meeting shall be fixed by the Council in its regular January meeting of each year, and notice thereof shall be published in the next JOURNAL of the association. Not less than thirty days before such meeting, written notices

shall be sent to all Delegates, in which notices shall be included the agenda for the meeting, on which agenda shall be a statement of each item to come before the meeting so far as is known to the Executive Secretary at the time the said notices are prepared for mailing. After the business listed on the agenda has been disposed of in the meeting, new business presented in the form of resolutions or motions from the floor will be considered and disposed of.

CHAPTER V.—ELECTION OF OFFICERS

Section 1.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the last day of the Annual Convention.

Sec. 2.—All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. In case no nominee receives a majority on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken.

Sec. 3.—Any person known to have solicited votes for or sought any office within the gift of this Association shall be ineligible for any office for two years.

Sec. 4.—The President, President-elect, and the Treasurer shall serve from the termination of the annual meeting of the House of Delegates in which the President-elect and Treasurer are elected until the termination of the succeeding annual meeting of the House of Delegates.

CHAPTER VI.—DUTIES OF OFFICERS

Section 1.—The President, or a member designated by him, shall preside at all general meetings of the Association and of the House of Delegates. The President shall appoint all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged by the Executive Committee, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and as far as practicable, shall visit by appointment the various sections of the state and assist the Councilors in building up the county societies and in making their work more practical and useful.

Sec. 2.—The President-elect's term of office shall be for one year, at the completion of which he succeeds to the presidency. While President-elect, he shall assist the President in the discharge of his duties.

Sec. 3.—The Treasurer shall give bond at the expense of the Association in such an amount as shall be required by the Council. He shall receive all bequests and donations to the Association and shall demand and receive all funds due the As-

sociation except accounts due THE JOURNAL in the conduct of its business. The funds of the Association shall be deposited in a depository or depositories designated by the Executive Committee, and withdrawals from such funds shall be made on checks or drafts signed by the Treasurer and the Chairman of the Council. He shall present to the House of Delegates annually a report of the receipts and expenditures, and the state of the funds in his hands, and shall subject his accounts to an annual audit by a Certified Public Accountant.

Sec. 4.—The Executive Secretary shall be the directing manager of the Association's headquarters and Journal offices, and shall supervise the work of all salaried employees in the Association offices. Such supervision shall be subject to directives from the House of Delegates, the Council, the Executive Committee, and the President of the Association. He shall discharge the administrative functions of the Association not within the duties of other officers or of committees to perform. He shall assist, at their request, all officers and committees, and shall keep himself informed in regard to non-professional matters affecting the medical profession, for the purpose of keeping himself qualified to perform the services herein mentioned. He shall be responsible for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the committees, the Council, and the officers of this Association. The amount of his salary shall be fixed by the Executive Committee on approval of the Council.

Sec. 5.—The necessary expenses of the above officers incurred in the line of duty herein imposed may be allowed by the Council, but excepting the Executive Secretary, this shall not include the expenses of attending the Annual Convention.

CHAPTER VII.—COUNCIL

Section 1.—The Council shall meet as follows: 1. January, April, and July of each year on dates and at places fixed by the Council. 2. On the day preceding the first day for the scientific meetings of the Annual Convention of the Association. 3. On the last day of the Annual Convention of the Association after the adjournment of the House of Delegates. 4. At such other times as necessity may require, subject to the call of the Chairman, or on petition of three Councilors. It shall hold no meeting that will conflict with any meeting of the House of Delegates. It shall elect a Chairman, and a Clerk, who, in the absence of the Executive Secretary of the Association, shall keep a record of its proceedings. It shall, through its Chairman, make an annual report to the House of Delegates.

Sec. 2. — Each Councilor shall be organizer, peacemaker, and censor for his district. He shall

visit the counties in his district at least once a year for the purpose of organizing component societies where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district, the same to be published in the number of *THE JOURNAL* which is issued immediately preceding the Annual Convention. The House of Delegates may take such action, if any, as it deems appropriate upon such reports. The necessary expenses incurred by such Councilor in the line of the duties herein imposed may be allowed by the Council on a properly itemized statement, but this shall not be construed to include his expense in attending the Annual Convention of the Association.

Sec. 3.—The Council shall, through its officers and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall study and strive constantly to make each Annual Convention a stepping stone to future ones of higher interest.

Sec. 4.—The Council shall, in connection with the House of Delegates, consider and advise as to the interests of the profession and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto.

Sec. 5.—The Council shall make careful inquiry into the condition of the profession of each county in the state and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of the same locality and shall continue these efforts until every physician in every county of the state who can be made reputable has been brought under medical society influence.

Sec. 6.—The Council shall encourage postgraduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

Sec. 7.—The Council shall, upon application, provide and issue charters to county societies organized to conform to the spirit of this Constitution and By-Laws.

Sec. 8.—In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies; and these societies, when organized and chartered, shall be entitled to all the

privileges and representation provided herein for county societies, until such counties may be organized separately.

Sec. 9.—The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standings of members whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the General or Section Meetings shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of component societies on which an appeal is taken from the decision of an individual Councilor, and its decision in all such matters shall be final.

Sec. 10.—The Council shall provide for and superintend all publications of the Association, and shall have authority to appoint an editor and such assistants as it deems necessary, and fix the amounts of their salaries. The proceedings of the Council for the year shall be reported to the House of Delegates at the Annual Convention and be published in the number of *THE JOURNAL* which immediately precedes the Annual Convention.

Sec. 11.—In the interim between the meetings of this Association the Council shall be the executive body of the Association with full power to fill vacancies or transact any business that emergencies or the welfare of the Association may require.

Sec. 12.—The Council shall elect two members of the Association, who, with the President, the President-elect, the Treasurer, and the Chairman of the Council, shall constitute and be known as the Executive Committee.

CHAPTER VIII.—STANDING COMMITTEES

Section 1.—The standing committees shall be as follows:

- The Executive Committee.
- Board of Appeals on Patient-Physician Relations.
- A Committee on Convention Arrangements.
- A Committee on Conference of County Medical Society Officers.
- A Committee on Scientific Work.
- A Committee on Scientific Exhibits.
- A Committee on Public Policy and Legislation.
- A Committee on Publicity.
- A Committee on Industrial Health.
- A Committee on Medical Education and Hospitals.
- A Committee on Public Relations.
- A Committee on Constitution and By-Laws.
- A Committee on Rural Health.

Such committees, except the Executive Committee, which is elected by the Council, shall be appointed by the President of the Association.

All members of committees shall serve for one year unless otherwise specified in these By-Laws or in the authorization for appointment.

Sec. 2.—*The Executive Committee*, consisting of six members as heretofore provided for shall meet on the call of the Chairman or of any three members with the Executive Secretary to plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Secretary's office. It shall constitute the Medical Defense Committee of the Association and shall have full authority governing all matters pertaining to the medical defense features of this Association, and shall be governed by the rules and regulations concerning such features as provided for in the By-Laws of this Association. It shall represent the Council during the intervals between meetings of that body, including matters pertaining to THE JOURNAL of the Association, and shall report its doings to the Council.

It shall prepare a budget for the ensuing calendar year; and all expenditures of the Association, except those otherwise provided for under the Constitution and By-Laws, shall be governed by the budget. No expense not provided for in the budget or otherwise under the Constitution and By-Laws shall be incurred by any officer or committee. A committee or an officer may submit a request for funds to meet unusual expenses not included in the annual budget, and the Executive Committee shall have the power, by a two-thirds vote, to amend the budget to provide such funds.

Sec. 3.—*The Committee on Convention Arrangements* shall consist of five or more members. With the advice and assistance of the Executive Secretary this committee shall provide suitable accommodations for the meetings of the Association, including the House of Delegates, Council, and of their respective committees, the scientific and technical exhibits, and in conjunction with the Executive Secretary shall have general charge of all the arrangements. Its chairman shall report an outline of the arrangements to the Executive Secretary of the Association for publication in THE JOURNAL and in the official program, and shall make additional announcements during the session as occasion may require. The arrangements for and the character of any and all technical exhibits must meet with the approval of the Executive Committee of the Association.

Sec. 4.—*The Committee on Scientific Work* shall consist of three or more appointive members appointed by the President; and of the chairman of the Committee on Scientific Exhibits and of the chairman of the sections as *ex officio* members. It shall be the duty of the officers of the various sections to prepare and submit to this committee prior to the first meeting of the committee a suggested program of subjects and personnel for their respective section programs for the Annual Convention. The scientific program

and the financial requirements to provide for it must be approved by the Executive Committee before the program is officially announced.

Sec. 5.—*The Committee on Scientific Exhibits* shall consist of five or more appointive members. It shall have the duty of arranging for scientific exhibits as a part of the Annual Convention, subject to the approval of the Executive Committee.

Sec. 6.—*The Committee on Public Policy and Legislation* shall consist of at least five or more appointive members. Under direction of the House of Delegates it shall represent the Association in securing and enforcing legislation in the interest of public health, medical education, scientific medicine, and the improvement of the medical profession. It shall keep in touch with professional and public opinion and shall endeavor to create and direct public opinion to the end that the public will demand adequate legislation for the promotion of the public good in relation to medicine and the enforcement of such legislation.

Sec. 7.—*The Committee on Publicity* shall consist of three appointive members. It shall be responsible for the dissemination of information concerning individual and community health to the lay public through articles prepared for publication in lay publications, and for addresses or talks delivered before lay audiences under the authority of the Association, and shall in every way seek to give the lay public a better knowledge and understanding of the aims and objects of scientific medicine.

Sec. 8.—*The Committee on Industrial Health* shall consist of five or more appointive members. The duties of the committee shall be: To study and gather facts and become intimately acquainted with the problems regarding industrial health, including any such problems as those relating to the prevention and cure of industrial injuries and diseases; to study the method and means of providing adequate medical and hospital care for those suffering from industrial diseases and injuries; and to encourage cooperation and mutual understanding among the members of the medical profession, employers of labor, employees and insurance carriers.

Sec. 9.—*The Committee on Medical Education and Hospitals* shall consist of five appointive members. The duties of this committee shall be to cooperate with the authorities of the Indiana University School of Medicine in efforts to improve the educational standards of the state as they pertain to the practice of medicine; to act in conjunction with the members of the Council in providing postgraduate clinics or teaching for the various Councilor medical districts of the state; to cooperate with the Hospital Council of the Indiana State Board of Health in connection with the making and recommending of rules and regulations for the management of hospitals; to select one of its own members as a delegate to

the yearly Conference on Medical Education and Hospitals of the American Medical Association; and to cooperate with the corresponding Council of the American Medical Association.

Sec. 10.—*The Committee on Public Relations* shall consist of five or more appointive members. The duties of the committee shall be to develop and carry on continuously a program to improve and sustain good will among the members of the medical profession and the general public; to study and assemble information regarding the means by which the interests of the public relations of the medical profession may best be served; to obtain through public and professional contacts and report to the profession through proper means information regarding the sentiments, criticism and suggestions for improvement which may be made either by members of the profession or by the lay public; and to have the special responsibility of furnishing leadership and guidance in keeping the medical profession as a whole within the deserved respect and esteem of the people.

Sec. 11.—*The Committee on Constitution and By-Laws* shall consist of five appointive members. The duties of this committee shall be: to keep in contact with the developments and changes in procedures in carrying on the work of this Association; to suggest revisions necessary to keep the Constitution and By-Laws always in accord with the practices and procedures best adapted to the functioning of the Association; and to keep the practices and procedures consistent with the provisions from time to time contained in the Constitution and By-Laws—to the end that all members of the profession, by reference to the Constitution and By-Laws, may be able to obtain accurate information regarding procedure and practices within the Association, and that hampering of such procedure and practice by obsolete provisions in the Constitution and By-Laws may be avoided.

Sec. 12.—*The Committee on Conference of County Medical Society Officers* shall consist of seven appointive members. It shall have the duty of arranging for conferences of County Medical Society Officers, preparing the agenda therefor, and fixing the time and place for such meetings.

Sec. 13.—A standing committee to be known as "The Board of Appeals on Patient-Physician Relations" shall be composed of nine physicians, three of whom shall be past presidents of the association, and all of whom shall be appointed by the president of the association. Not more than one physician shall be appointed from any one Councilor District. No member shall hold any elective office in the state association during tenure on this committee. Of the nine physicians first appointed, three, including one past president, shall serve for a period of one year; three, including one past president, for two years; three, including one past

president, for three years. Thereafter three shall be appointed each year for a three year term, to fill the vacancies caused by the expiration of terms. Any vacancy occurring in this committee other than by expiration of terms shall be filled by an interim appointee to serve the balance of the unexpired term. This committee shall organize itself by electing a chairman, vice-chairman, and secretary.

Sec. 14.—The duties of this Board of Appeals on Patient-Physician Relations shall be to receive complaints, appeals or suggestions from physicians or laymen concerning professional conduct. It shall attempt to find the facts regarding any matter brought to its attention, through procedures proper and appropriate to that end, and shall attempt to adjust differences between patients and physicians. It may, if it believes the facts justify such action, cite the member to the Council of the state association. It shall, subject to the approval of the Council, draw up a set of rules and regulations governing the procedure and official actions of the Board.

Sec. 15.—The President and Executive Secretary shall be *ex officio* members of all the foregoing standing Committees where their inclusion on the committee is not otherwise provided for in these By-Laws.

CHAPTER IX.—SPECIAL COMMITTEES

The President may appoint such other committees in addition to the standing committees as he deems necessary or as may be specially authorized by the House of Delegates, the Council, or the Executive Committee. Any such committees shall be known as special committees.

CHAPTER X.—REFERENCE COMMITTEES

Section 1.—Immediately after the organization of the House of Delegates at each Annual Convention, the President shall announce the membership of the reference committees to serve during the convention for which they are appointed. Appointments to these reference committees shall be made by the President in time for them to be published in *THE JOURNAL* and the Handbook prior to such Annual Convention.

The President shall have the power to appoint substitutes from among the members present for absent appointees.

Each committee shall consist of five members, the chairman to be specified by the President. To these committees shall be referred all reports, resolutions, measures and propositions presented to the House of Delegates, except such matters as properly come before the Council, and the recommendations of these committees shall be submitted to the next meeting of the House of Delegates for acceptance in the original or modified form or for rejection.

Sec. 2.—The following reference committees are hereby constituted:

(1) A Committee on Sections and Section Work to which shall be referred all matters relating to the sections or section work.

(2) A Committee on Rules and Order of Business to which shall be referred all matters regarding rules governing the action, methods of procedure, and order of business of the House of Delegates.

(3) A Committee on Medical Education and Hospitals to which shall be referred all matters relating to medical education and medical colleges and hospitals.

(4) A Committee on Public Policy and Legislation to which shall be referred all matters relating to state and national legislation, and memorials to the legislature, to the United States Congress, to the Governor of the State, or to the President of the United States.

(5) A Committee on Publicity to which shall be referred all matters relating to publicity.

(6) A Committee on Hygiene and Public Health to which shall be referred all matters relating to hygiene and public health.

(7) A Committee on Amendments to the Constitution and By-Laws to which shall be referred all proposed amendments to the Constitution and By-Laws.

(8) A Committee on Reports of Officers to which shall be referred the address of the President and the reports of the Executive Secretary, Treasurer, and the Council.

(9) A Committee on Credentials to which shall be referred all questions regarding registration and the credentials of delegates.

(10) A Committee on Miscellaneous Business to which shall be referred all business not otherwise disposed of.

Sec. 3.—The time and place of meetings of all reference committees shall be publicly posted, and all meetings of all reference committees shall be open to all members of the Association.

Officers and chairmen of all committees whose reports are referred to reference committees shall have the right to appear and be heard before the respective committees to which such references are made, in regard to their reports.

CHAPTER XI.—COUNTY SOCIETIES

Section 1.—All county societies now in affiliation with this Association or those which may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws, shall, on

application, receive a charter from and become a component part of this Association. The acceptance or retention of this charter shall be regarded as a pledge on the part of said component society to conduct itself in harmony with the letter and spirit of this Constitution and By-Laws and other rules and resolutions of this Association.

Sec. 2.—Charters shall be issued only upon approval of the Council and shall be signed by the President and Executive Secretary of this Association. The Council shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and By-Laws.

Sec. 3.—Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Councilor for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Sec. 4.—Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who does not practice or claim to practice, nor lend his support to, any exclusive system of medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

Sec. 5.—Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, and its decision shall be final.

Sec. 6.—In hearing appeals the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a board and as individual Councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Sec. 7.—When a member in good standing in a component society moves to another county in this state his name, on request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves, provided the transfer is approved by majority vote of the membership of said society to which the membership is proposed.

Sec. 8.—A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he has his office or has the major part of his practice.

Sec. 9.—Each component society, shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and professional status of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified and honorable physician in the county.

Sec. 10.—At the annual business meeting for election of other officers, in advance of the Annual Convention of this Association, each county society shall elect delegates and alternates to represent it in the House of Delegates of this Association, and the secretary of the society shall send a list of such delegates and alternates to the Executive Secretary of this Association annually on or before August first.

Sec. 11.—The secretary of each component society shall keep a roster of all its members and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such roster the secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

The secretary of each component society shall prepare and send to the Councilor of his district a quarterly report briefly stating the activities of his county society including meetings, programs, changes in officers and personnel of membership. A copy of this quarterly report to the Councilor shall also be sent to the Executive Secretary of the State Association. The State Association shall supply each county secretary a form for these reports.

Sec. 12.—The fiscal year of the Association shall be the calendar year, and all dues shall be for the year and *payable in advance*. The secretary of each component society shall forward the dues for his society, together with the roster of officers and members and list of non-affiliated physicians of the county, to the Executive Secretary of this Association, on or before January 1 of each year and he shall promptly report thereafter the names of any new members elected to membership in his society, and promptly forward to the Executive Secretary of this Association the dues for such new members. The dues shall be the same for all members and entitle the members to all benefits, including the publications of this Association, from the time of paying the dues to the close of the year only. Provided, however, that physicians elected to their first membership in this Association during the first nine months of any year shall pay the regular annual dues for that year; and those elected to their first

membership after October 1 of any one year shall pay \$10.00 as dues for the remainder of that year. Interns and residents shall pay \$10.00 a year annual dues during their term of service in the hospital. In the event the county society remits a member's dues for good cause, and the secretary of the county medical society recommends in writing the remission of the state association dues of said member of the society, and shows good cause why such recommendation should be granted, the Council shall have the power to remit such dues.

Sec. 13.—Any county society which fails to pay its dues or make the report required by February 1 of each year shall be held suspended, and none of its members or delegates shall be permitted to receive any of the publications of the Association or participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Sec. 14.—Each county society shall be held responsible for the faithfulness in the performance of duty on the part of its secretary in making reports and remitting dues to the Association.

Sec. 15.—Each component society shall have its own Constitution and By-Laws, not in conflict with the Constitution and By-Laws either of this Association or of the American Medical Association, a copy of which shall be filed with the Executive Secretary of this Association; and furthermore, the Executive Secretary shall be notified at once of any changes or amendments that may be made from time to time.

CHAPTER VII.—MISCELLANEOUS

Section 1.—The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, when not in conflict with this Constitution and By-Laws.

Sec. 2.—The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

CHAPTER VIII.—MEDICAL DEFENSE

Section 1.—One dollar and twenty-five cents out of the annual dues of each member of the Association shall be set aside as a special fund for medical defense.

Sec. 2.—The administration of medical defense of this Association shall be intrusted to the Executive Committee, which shall constitute the Medical Defense Committee of the Association.

Sec. 3.—This committee shall have full authority governing all matters pertaining to the medical defense features of this Association; with power to enter into agreement for the payment of fees of one attorney whom the physician sued shall have the right to choose, provided such attorney is of good reputation and standing at the

bar, and to employ expert witnesses and incur such other expenses as in the judgment of the committee may be necessary in the defense of members against whom suits may be brought; provided, always, that the total expenditure in any single suit shall not exceed 25 per cent of the fund available at the time suit is filed; and provided further that this Association shall not be liable for attorney's fees in such suits unless this committee shall have first agreed in each case with the physician sued and the attorneys representing him in regard to the terms of such employment, including the fees to be paid.

Sec. 4.—The Treasurer of the Indiana State Medical Association shall be custodian of the defense fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee. Payments out of this fund shall be made only upon approval of the Executive Committee, by checks signed by the Treasurer and the Chairman of the Council.

Sec. 5.—The Medical Defense Committee shall make an annual report to the House of Delegates of the cases in which it has been of service to members and furnish an account of the money received and expended, such report to be published in THE JOURNAL of the Indiana State Medical Association at the time and in the manner that reports of other committees of the Association are published.

Sec. 6.—This Association shall not be liable for any damage awarded, but shall be liable only for such expenses for the legal defense of its members as may be incurred in accordance with the terms of these By-Laws:

Sec. 7.—The Association shall not undertake the defense of a member in any case in which the member who applies for medical defense by the Association has failed to pay his annual dues for the year in which services were rendered which are the basis of the suit; and medical defense by the Association shall not be available in any suit based on services rendered during any period of delinquency in the payment of dues. Dues are payable on January 1, and become delinquent on February 1 of each year. The membership card of this Association, duly signed and dated by the Executive Secretary, shall be considered the only *bona fide* evidence of payment of dues or membership in this Association.

The Indiana State Medical Association shall in no case provide medical defense against any action for alleged malpractice against any physician unless such physician was a member of this Association in good standing at the time the services which are the basis of the suit were rendered.

Sec. 8.—A member desiring to avail himself of the services of the Medical Defense Committee in connection with litigation brought or threatened must send to the Executive Secretary of the Association for an application blank. After completing the data concerning the case he shall submit to a local committee of his county medical

society—to be composed of the President, Secretary and one other member in good standing who may be nominated by the defendant—a full statement of the question at issue, including the diagnosis and treatment of the case and the names of physicians, nurses and other persons having knowledge of the same, who may be summoned as witnesses.

Sec. 9.—The committee of the county medical society shall immediately, after an investigation of all the circumstances and facts, transmit its report, with recommendations, to the Medical Defense Committee of this Association.

Sec. 10.—In the event that the county committee shall fail to recommend the case as one worthy of the recognition of this Association, a direct appeal may be made to the Medical Defense Committee of this Association, whose decision shall be final.

Sec. 11.—Suits brought against the estate of a deceased member shall be defended as if that member were alive; provided that such member was in good standing in the Association at the time of his death and that services for which indemnity is asked were rendered while the deceased was a member in good standing.

Sec. 12.—Medical defense shall not be available to members living outside of the State of Indiana at the time services were rendered for which indemnity is claimed.

Sec. 13.—The Medical Defense Committee shall have power to adopt such other rules, not in conflict with the foregoing, as in their judgment may seem necessary.

Sec. 14.—Medical defense as provided for by this Association shall be available to members under the terms stated in these By-Laws only in the defense of civil action for alleged malpractice, and shall not be available if such alleged malpractice occurred when the member was under the influence of any intoxicant or narcotic while rendering the service in question.

CHAPTER XIV.—DIVISION OF FEES

This Association does not countenance or tolerate fee-splitting, division of fees, or commission paying directly or indirectly, and any member found guilty shall be expelled from membership.

CHAPTER XV.—INVESTMENT OF SURPLUS FUNDS

Section 1.—All surplus funds of this association shall hereafter be invested only in United States Government bonds or in municipal bonds which the United States Government or the municipalities issuing such bonds shall have the direct obligation to pay.

CHAPTER XVI.—AMENDMENTS

Section 1.—These By-Laws may be amended at any Annual Convention by a majority vote of all the delegates present at that convention, after the amendment has lain on the table for one day.

Sec. 2.—Upon the adoption of this Constitution and By-Laws all previous Constitutions and By-Laws are hereby repealed.

PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION†

"These principles are not laws to govern but are principles to guide to correct conduct." (James Percival's *Principles of Ethics* 1803.)

CHAPTER I

GENERAL PRINCIPLES

CHARACTER OF THE PHYSICIAN

SECTION 1.—The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Whoever chooses this profession assumes the obligation to conduct himself in accord with its ideals. A physician should be "an upright man, instructed in the art of healing." He must keep himself pure in character and be diligent and conscientious in caring for the sick. As was said by Hippocrates, "He should also be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life."

THE PHYSICIAN'S RESPONSIBILITY

SEC. 2.—"The profession of medicine, having for its end the common good of mankind, knows nothing of national enmities, of political strife, of sectarian dissensions. Disease and pain the sole conditions of its ministry, it is disquieted by no misgivings concerning the justice and honesty of its client's cause; but dispenses its peculiar benefits, without stint or scruple, to men of every country, and party and rank, and religion, and to men of no religion at all."*

GROUPS AND CLINICS

SEC. 3.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

ADVERTISING

SEC. 4.—Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned. Self laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved.

EDUCATIONAL INFORMATION NOT ADVERTISING

SEC. 5.—Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not easily accessible or readily understandable.

The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. The adaptability of medical material for presentation to the public may be perceived first by publishers, motion picture producers or radio officials. These may offer to the physician opportunity to release

to the public some article, exhibit or drawing.[§] Refusal to release the material may be considered a refusal to perform a public service, yet compliance may bring the charge of self seeking or solicitation. In such circumstances the physician should be guided by the decision of official agencies established through component and constituent medical organizations.

A physician who desires to know whether, ethically, he may engage in a project aimed at health education of the public should request the approval of the designated officer or committee of his county medical society.

The most worthy and effective advertisement possible, even for a young physician, especially among his brother physicians, is the establishment of a well merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical.

The promise of radical cures or boasting of cures or of extraordinary skill or success is unethical.

An institution may use means, approved by the medical profession in its own locality, to inform the public of its address and the special class, if any, of patients accommodated.

PATENTS, COMMISSIONS, REBATES AND SECRET REMEDIES

SEC. 6.—An ethical physician will not receive remuneration from patents on or the sale of surgical instruments, appliances and medicines, nor profit from a copyright on methods or procedures. The receipt of remuneration from patents or copyrights tempts the owners thereof to retard or inhibit research or to restrict the benefits derivable therefrom to patients, the public or the medical profession. The acceptance of rebates on prescriptions or appliances, or of commissions from attendants who aid in the care of patients is unethical. An ethical physician does not engage in barter or trade in the appliances, devices or remedies prescribed for patients, but limits the sources of his professional income to professional services rendered the patient. He should receive his remuneration for professional services rendered only in the amount of his fee specifically announced to his patient at the time the service is rendered or in the form of a subsequent statement, and he should not accept additional compensation secretly or openly, directly or indirectly, from any other source.

The prescription or dispensing by a physician of secret medicines or other secret remedial agents, of which he does not know the composition, or the manufacture or promotion of their use is unethical.

EVASION OF LEGAL RESTRICTIONS

SEC. 7.—An ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such laws.

CHAPTER II

DUTIES OF PHYSICIANS TO THEIR PATIENTS STANDARDS, USEFULNESS, NONSECTARIANISM

SECTION 1.—In order that a physician may best serve his patients, he is expected to exalt the standards of his profession and to extend its sphere of usefulness. To the same end, he should not base his practice on an exclusive dogma or a sectarian system, for "sects are implacable despots; to accept their thralldom is to take away all liberty from one's action and thought."* A sectarian or cultist as applied to medicine is one who alleges to follow or in his practice follows a dogma, tenet or principle based on the authority of its promul-

† Adopted by the American Medical Association House of Delegates on June 6, 1949.

* Sir Thomas Watson.

* Nicon, father of Galen.

gator to the exclusion of demonstration and scientific experience. All voluntarily associated activities with cultists are unethical. A consultation with a cultist is a futile gesture if the cultist is assumed to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice.

PATIENCE, DELICACY AND SECRECY

SEC. 2.—Patience and delicacy should characterize the physician. Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the "disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the state. Sometimes, however, a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidences entrusted to him as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would desire another to act toward one of his own family in like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

PROGNOSIS

SEC. 3.—The physician should neither exaggerate nor minimize the gravity of a patient's condition. He should assure himself that the patient, his relatives or his responsible friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

THE PATIENT MUST NOT BE NEGLECTED

SEC. 4.—A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant.

CHAPTER III

DUTIES OF PHYSICIANS TO EACH OTHER AND TO THE PROFESSION AT LARGE

ARTICLE I.—DUTIES TO THE PROFESSION UPHOLDING THE HONOR OF THE PROFESSION

SECTION 1.—A physician is expected to uphold the dignity and honor of his vocation.

MEMBERSHIP IN MEDICAL SOCIETIES

SEC. 2.—For the advancement of his profession, a physician should affiliate with medical societies and contribute of his time, energy and means so that these societies may represent the ideals of the profession.

SAFEGUARDING THE PROFESSION

SEC. 3.—Every physician should aid in safeguarding the profession against admission to it of those who are deficient in moral character or education.

SEC. 4.—A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. Questions of such conduct should be considered, first, before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations, provided such a course is possible and provided, also, that the law is not hampered thereby. If doubt should arise as to the legality of the physician's conduct, the situation under investigation may be placed before officers of the law, and the physician-investigators may take the necessary steps to enlist the interest of the proper authority.

ARTICLE II.—PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER

DEPENDENCE OF PHYSICIANS ON EACH OTHER

SECTION 1.—As a general rule, a physician should not attempt to treat members of his family or himself. Consequently, a physician should cheerfully and without recompense give his professional services to physicians or their dependents if they are in his vicinity.

COMPENSATION FOR EXPENSES

SEC. 2.—When a physician from a distance is called to advise another physician about his own illness or about that of one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered him. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss may, in part at least, be provided for in the compensation offered.

ONE PHYSICIAN IN CHARGE

SEC. 3.—When a physician or a member of his dependent family is seriously ill, he or his family should select one physician to take charge of the case. The family may ask the physician in charge to call in other physicians to act as consultants.

ARTICLE III.—DUTIES OF PHYSICIANS IN CONSULTATIONS

CONSULTATIONS SHOULD BE ENCOURAGED

SECTION 1.—In a case of serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

CONSULTATION FOR PATIENT'S BENEFIT

SEC. 2.—In every consultation, the benefit to the patient is of first importance. All physicians interested in the case should be candid with the patient, a member of his family or a responsible friend.

PUNCTUALITY

SEC. 3.—All physicians concerned in consultations should be punctual. When, however, one or more of the consultants are unavoidably delayed, the one who arrives first should wait for the others for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any other reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or if it be the desire of the patient, his family or his responsible friends, the consultant may examine the patient and mail his written opinion, or see that it is delivered under seal to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

PATIENT REFERRED TO CONSULTANT

SEC. 4.—When a patient is sent to a consultant and the physician in charge of the case cannot accompany the patient, the physician in charge should provide the consultant with a history of the case, together with the physician's opinion and outline of the treatment, or so much of this as may be of service to the consultant. As soon as possible after the consultant has seen the patient he should address the physician in charge and advise him of the results of the consultant's investigation. The opinions of both the physician in charge and the consultant are confidential and must be so regarded by each.

DISCUSSIONS IN CONSULTATION

SEC. 5.—After the physicians called in consultation have completed their investigations, they and the physician in charge should meet by themselves to discuss the course to be followed. Statements should not be made, nor should discussion take place in the presence of the patient, his family or his friends, unless all physicians concerned are present or unless all of them have consented to another arrangement.

RESPONSIBILITY OF ATTENDING PHYSICIAN

SEC. 6.—The physician in charge of the case is responsible for treatment of the patient. Consequently, he may prescribe for the patient at any time and is privileged to vary the treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, after such a change, it is best to call another consultation; then the physician in charge should state his reasons for departing from the course decided at the previous conference. When an emergency occurs during the absence of the physician in charge, a consultant may assume authority until the arrival of the physician in charge, but his authority should not extend further without the consent of the physician in charge.

CONFLICT OF OPINION

SEC. 7.—Should the physician in charge and a consultant be unable to agree in their view of a case, another consultant should be called or the differing consultant should withdraw. However, since the patient employed the consultant to obtain his opinion, he should be permitted to state it to the patient, his relative or his responsible friend, in the presence of the physician in charge.

CONSULTANT AND ATTENDANT

SEC. 8.—When a physician has acted as consultant in an illness, he should not become the physician in charge in the course of that illness, except with the consent of the physician who was in charge at the time of the consultation.

ARTICLE IV.—DUTIES OF PHYSICIANS IN CASES OF INTERFERENCE

MISUNDERSTANDINGS TO BE AVOIDED

SECTION 1.—A physician, in his relationship with a patient who is under the care of another physician, should not give hints relative to the nature and treatment of the patient's disorder; nor should a physician do anything to diminish the trust reposed by the patient in his own physician. In embarrassing situations, or whenever there seems to be a possibility of misunderstanding with a colleague, a physician should seek a personal interview with his fellow.

SOCIAL CALLS ON PATIENT OF ANOTHER PHYSICIAN

SEC. 2.—When a physician makes social calls on another physician's patient he should avoid conversation about the patient's illness.

SERVICES TO PATIENT OF ANOTHER PHYSICIAN

SEC. 3.—A physician should not take charge of, or prescribe for another physician's patient during any given illness (except in an emergency) until the other physician has relinquished the case or has been formally dismissed.

CRITICISM TO BE AVOIDED

SEC. 4.—When a physician does succeed another physician in charge of a case, he should not disparage, by comment or insinuation, the one who preceded him. Such comment or insinuation tends to lower the confidence of the patient in the medical profession and so reacts against the patient, the profession and the critic.

EMERGENCY CASES

SEC. 5.—When a physician is called in an emergency because the personal or family physician is not at hand, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the personal or family physician. However, he should first report to the personal or family physician the condition found and the treatment administered.

PRECEDENCE WHEN SEVERAL PHYSICIANS ARE SUMMONED

SEC. 6.—When several physicians have been summoned in a case of sudden illness or of accident, the first to arrive should be considered the physician in charge. However, as soon as is practicable, or on the arrival of the acknowledged personal or family physician, the first physician should withdraw. Should the patient, his fam-

ily or his responsible friend wish some one other than he who has been in charge of the case, the patient or his representative should advise the personal or family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital without the knowledge of the physician who is known to be the personal or family physician, the patient should be returned to the care of the personal or family physician as soon as is feasible.

A COLLEAGUE'S PATIENT

SEC. 7.—When a physician is requested by a colleague to care for a patient during the colleague's temporary absence, or when, because of an emergency, a physician is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy that he would wish used in similar circumstances if the patient were his responsibility. The patient should be returned to the care of the attending physician as soon as possible.

SUBSTITUTION IN OBSTETRIC WORK

SEC. 8.—When a physician attends a woman who is in labor because the one who was engaged to attend her is absent, the physician summoned in the emergency should relinquish the patient to the first engaged, on his arrival. The one in attendance is entitled to compensation for the professional services he may have rendered.

ARTICLE V.—DISPUTES BETWEEN PHYSICIANS
ARBITRATION

SECTION 1.—Whenever there arises between physicians a grave difference of opinion, or of interest, which cannot be promptly adjusted, the dispute should be referred for arbitration, preferably to an official body of a component society.

ARTICLE VI.—COMPENSATION
LIMITS OF GRATUITOUS SERVICE

SECTION 1.—Poverty of a patient, and the obligation of physicians to attend one another and the dependent members of the families of one another, should command the gratuitous services of a physician. Institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, should meet such costs as are covered by the contract under which the service is rendered.

CONDITIONS OF MEDICAL PRACTICE

SEC. 2.—A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care.

CONTRACT PRACTICE

SEC. 3.—Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

FREE CHOICE OF PHYSICIAN

SEC. 4.—Free choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians. The interjection of a third party who has a valid interest, or who intervenes between the physician and the patient does not *per se* cause a contract to be unethical. A third party has a valid interest when, by law or volition, the third party assumes legal responsibility and provides for the cost

of medical care and indemnity for occupational disability.

COMMISSIONS

SEC. 5.—When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, the giving or receiving of a commission by whatever term it may be called or under any guise or pretext whatsoever is unethical.

PURVEYAL OF MEDICAL SERVICE

SEC. 6.—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

CHAPTER IV

THE DUTIES OF PHYSICIANS TO THE PUBLIC PHYSICIANS AS CITIZENS

SECTION 1.—Physicians, as good citizens, possessed of special training, should advise concerning the health of the community wherein they dwell. They should bear their part in enforcing the laws of the community and in sustaining the institutions that advance the interests

of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations.

PUBLIC HEALTH

SEC. 2.—Physicians, especially those engaged in public health work, should enlighten the public concerning quarantine regulations and measures for the prevention of epidemic and communicable diseases. At all times the physician should notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities. When an epidemic prevails, a physician must continue his labors without regard to the risk to his own health.

PHARMACISTS

SEC. 3.—Physicians should recognize and promote the practice of pharmacy as a profession and should recognize the cooperation of the pharmacist in education of the public concerning the practice of ethical and scientific medicine.

CONCLUSION

These principles of medical ethics have been and are set down primarily for the good of the public and should be observed in such a manner as shall merit and receive the endorsement of the community. The life of the physician, if he is capable, honest, decent, courteous, vigilant and a follower of the Golden Rule, will be in itself the best exemplification of ethical principles.

DEATHS OF INDIANA PHYSICIANS IN 1952

(Compiled by James B. Maple, M.D., Sullivan, chairman of Committee on Necrology)
(M) Member I.S.M.A.; (S) Senior Member; (R) Retired

Name	Age	Date of Death	Address	Cause of Death
Downey, Louis J. (R)	76	Jan. 3	Vincennes	Coronary infarction, arteriosclerosis
Coomes, M. Joseph (S)	81	Jan. 6	Shelbyville	Struck by auto, fracture of femur
Berger, Henry I. (M)	64	Jan. 7	Indianapolis	Cerebral thrombosis, arteriosclerosis
Shonkwiler, Allen J. (R)	72	Jan. 10	Rockville	Coronary occlusion
Casper, Joseph F. (M)	63	Jan. 18	Jasper	Cerebral hemorrhage
Stickler, Benjamin F. (R)	67	Jan. 18	Columbia City	Cerebral hemorrhage, diabetes mellitus
O'Leary, Francis T. (M)	77	Jan. 22	Logansport	Coronary occlusion, arteriosclerotic heart disease
Openshaw, James F. (M)	44	Jan. 23	Goodland	Anuria, hepato-renal syndrome, portal cirrhosis
Yung, J. Rudolph (M)	73	Jan. 29	Terre Haute	Acute myocardial infarction
Kemp, Milburn W. (M)	57	Feb. 6	Madison	Rupture of aortic aneurysm
Parker, Ernest E. (S)	77	Feb. 9	Oxford	Carcinoma of the prostate, peritonitis, perforation of urinary bladder
Eisaman, Cecil L. (M)	52	Feb. 10	Marion	Cirrhosis of the liver
Grossman, Wm. L. (M)	72	Feb. 10	North Vernon	Overdose of sedative (coroner's verdict).
Swezey, Harry N. (M)	72	Feb. 12	Lafayette	Congestive heart failure, arteriosclerotic heart failure, monocytic leukemia
Heller, Oscar S. (S)	79	Feb. 14	Greenfield	Cerebral embolus, chronic auricular fibrillation
Erdman, Bernard (M)	75	Feb. 16	Indianapolis	Coronary thrombosis, coronary arteriosclerosis
Grayston, Fred W. (S) (R)	81	Feb. 20	Huntington	Chronic myocarditis, generalized arteriosclerosis
Nehil, Lawrence W. (M)	46	Mar. 2	Indianapolis	Prostatic abscess, suppurative prostatitis
Gordin, Stanton E. (M)	81	Mar. 4	Alquina	Acute nephritis. Chronic myocarditis
McMahan, Herbert G. (M)	40	Mar. 4	Westville	Suffocation from fire
Wallace, Edward R. (M)	75	Mar. 7	Aurora	Cerebral hemorrhage, arteriosclerosis, hypertension

Name	Age	Date of Death	Address	Cause of Death
Lillie, Park A.	84	Mar. 8	Cloverdale	Arteriosclerotic heart disease, generalized arteriosclerosis
Roberts, William J. (R)	79	Mar. 14	Logansport	Coronary occlusion, valvular heart disease
Jordan, Cecil J. (R)	74	Mar. 15	Denver	Coronary occlusion, generalized arteriosclerosis
Nesbit, Otis B. (S)	81	Mar. 18	Gary	Coronary occlusion
Naugle, Raymond A. (M)	56	Mar. 21	Wabash	Brain tumor
McMeel, James E. (M)	63	Mar. 26	South Bend	Acute myocardial infarction arteriosclerotic heart disease
Heberer, Joseph M. (M)	73	Apr. 2	Evansville	Cerebral hemorrhage, hypertensive cardiovascular disease
Olney, Thomas A. (S)	81	Apr. 4	Chesterton	Carcinoma of the pancreas
Cluthe, Walter J. (R)	70	Apr. 7	Evansville	Cardiovascular renal disease
Pectol, Charles F. (M)	85	Apr. 7	Spencer	Cerebral hemorrhage
Layman, Daniel W. (M)	79	Apr. 21	Indianapolis	Arteriosclerotic heart disease, nephrosclerosis
Brookie, Roger W. (M)	69	Apr. 22	Flora	Heart failure
Ridenour, David C. (S)	83	Apr. 25	Peru	Cardiovascular renal disease
Ragsdale, Harrison C. (M)	57	Apr. 26	Bedford	Cirrhosis of the liver
Bartholomew, Alfred C. (M)	72	Apr. 27	Fort Wayne	Myocardial infarction
Mervis, Frank H. (M)	61	May 8	East Chicago	Cerebral hemorrhage
Porter, MacGuyer (S)	85	May 12	Elnora	Coronary thrombosis, chronic diabetes
Sandoz, Louis A. (M)	56	May 13	South Bend	Adenocarcinoma of the colon, peritonitis
Wiggins, George (M)	48	May 17	New Castle	Coronary occlusion, arteriosclerosis
Glaser, Robert (M)	41	May 20	Brookville	Accidental carbon monoxide poisoning
Records, Robert S.	82	May 21	Lawrence	Myocardial degeneration
Beeler, Bruce H. (M)	64	May 23	Evansville	Cancer and cirrhosis of the liver
Vander Bogart, Harry E. (M)	68	May 23	Goshen	Carcinoma of the ascending colon
Black, Vinton G.	77	May 28	Noblesville	Coronary occlusion, arteriosclerosis
Kidd, James W. (R)	78	May 29	Fort Wayne	Arteriosclerotic heart disease
Price, Melvin D. (S)	81	May 31	Nappanee	Acute myocardial infarction, coronary sclerosis
Totten, Evan C. (S)	77	June 2	Madison	Acute congestive heart failure, arteriosclerotic heart disease
Haynes, John S. (M)	34	June 5	Evansville	Overdose of sleeping pills, suicide
Warren, Bradford (M)	71	June 6	Marshall	Coronary insufficiency, chronic rheumatic heart disease
Copeland, George W. (S)	79	June 7	Vevay	Cerebral hemorrhage
English, Harry E. (M)	54	June 7	Rensselaer	Myocardial infarction, coronary occlusion
Stephens, Robert C. (R) (S)	83	June 8	Plymouth	Arteriosclerotic heart disease
Lohrmann, Henry (R)	81	June 9	Indianapolis	Arteriosclerosis, diabetes mellitus
Moore, Robert M. (M)	67	June 23	Indianapolis	Pulmonary embolism
Baldrige, Odus L.	71	June 25	Terre Haute	Coronary occlusion
Gunn, Neil M.	68	June 29	Michigan City	Myocardial insufficiency, coronary arteriosclerosis
Cunningham, John M. (S)	75	June 29	Indianapolis	Multiple myeloma, cerebral thrombosis
Ferrell, Jesse E. (M)	71	July 2	Fortville	Cerebral hemorrhage, hypertension
Spink, Urbana (M)	73	July 5	Indianapolis	Generalized carcinomatosis
Reusser, Amos (S)	82	July 9	Berne	Coronary embolism
Lynch, Paul V. (M)	61	July 9	Evansville	Coronary thrombosis
White, Claude H. (R)	77	July 11	Mooreville	Cerebral hemorrhage
Casper, John P. (M)	70	July 12	Jasper	Carcinoma of the pancreas
Schenk, George M. (R)	77	July 19	Ridgeville	Subdural hemorrhage, hypertension, diabetes
Gillespie, Chauncey M. (M)	75	July 29	Rome City	Cerebral hemorrhage, hypertension
Bigelow, Oliver P. (M)	67	July 30	Roanoke	Coronary thrombosis
Taylor, Eugene C. (M)	73	Aug. 5	Evansville	Cerebral hemorrhage, hypertension
Conner, Thomas E. (S)	79	Aug. 7	Freetown	Cardiovascular renal disease
Elliott, Roy H. (R)	76	Aug. 15	Indianapolis	Acute myocardial infarction
Shanks, Roy E. (M)	55	Aug. 19	Rushville	Coronary occlusion
Parrish, Rebecca (R)	82	Aug. 22	Indianapolis	Malnutrition, anemia
Gutierrez, Frank A. (M)	55	Aug. 22	Gary	Coronary thrombosis
Rariden, Lawrence B. (M)	66	Aug. 26	Greenfield	Cerebral thrombosis
Leslie, Ernil T. (M)	48	Aug. 27	Evansville	Introcranial hemorrhage from a fall
Gordin, Stanley B. (M)	47	Sept. 1	Alquina	Coroner's finding "Open"
Porter, Miles F. (M)	65	Sept. 4	Fort Wayne	Coronary thrombosis

Name	Age	Death Date of	Address	Cause of Death
DeNaut, James L. (S) (R)	82	Sept. 4	Hamlet	Cerebrothrombosis
Smith, Arthur J. (R)	79	Sept. 7	Portland	Coronary thrombosis
King, James R. (M)	83	Sept. 15	Silver Lake	Suicide
Rogers, Robert C. (S)	82	Oct. 6	Bloomington	Hypostatic pneumonia, cardiovascular renal disease
Moschelle, Judson D.	74	Oct. 10	Indianapolis	Cerebral hemorrhage
Kidder, John J. (M)	81	Oct. 11	Salamonia	Arteriosclerotic heart disease
Rosenfeld, Norman B. (M)	40	Oct. 21	Clinton	Overdose of narcotics
Iddings, John W. (M)	73	Oct. 21	Crown Point	Aortic aneurysm
Schuler, Russell P. (R) (M)	69	Oct. 24	Kokomo	Cerebral apoplexy
Morr, John W. (M)	81	Oct. 25	Albion	Uremia and chronic nephritis
Leatherman, Cameron A. (M)	67	Oct. 25	Muncie	Myocardial infarction, coronary sclerosis
Chittick, A. Golding (M)	69	Oct. 26	Frankfort	Myocardial infarction
Montgomery, James R. (M)	73	Oct. 29	Owensville	Coronary occlusion
Hare, John W. (M)	59	Oct. 30	Evansville	Cerebrovascular accident
Mitchell, Albert M. (M)	64	Nov. 10	Terre Haute	Arteriosclerotic heart disease
Underwood, Gordon B. (M)	67	Nov. 10	Evansville	Congestive heart failure
Dickason, Francis M. (R)	84	Nov. 11	Bluffton	Myocardial fibrosis, coronary arteriosclerosis
Parsons, Marion M.	83	Nov. 13	Dubois	Arteriosclerosis
Cahal, Ernest E. (M)	69	Nov. 18	Indianapolis	Coronary occlusion with myocardial infarction
Johnson, Jesse J. (S)	79	Nov. 28	Milltown	Adenocarcinoma of the stomach
Bland, Herbert E. (S)	79	Nov. 30	Fairbanks	Arteriosclerosis, chronic nephritis, mitral regurgitation
Baldwin, Verne E.	76	Dec. 4	Amboy	Hypertensive heart, diabetes
Sourwine, Clint C. (M)	70	Dec. 5	Brazil	Carcinoma of the bladder, cerebral hemorrhage
Barker, Mary A.	90	Dec. 6	Bloomington	Bronchopneumonia, senility
Brown, Stanley L. (M)	68	Dec. 8	Hammond	Cerebral hemorrhage
Baker, Clarence S. (M)	70	Dec. 14	Evansville	Cerebrovascular accident
Garber, Paul A. (M)	60	Dec. 24	South Whitley	Cerebral hemorrhage
Rice, Thurman B. (M)	64	Dec. 27	Indianapolis	Coronary occlusion
Schwartz, William D. (R)	82	Dec. 28	Portland	Squamous cell carcinoma left axilla
Pfafflin, Charles A. (R) (M)	79	Dec. 30	Indianapolis	Cerebral thrombosis



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ELECTIVE INDUCTION OF LABOR

THE elective induction of labor in normally pregnant women has been advocated by several obstetricians during the past few years. A serious problem is presented because many of the advocates of this practice hold teaching positions in medical centers. The common reasons given for elective induction are: the anxiety of the patient, and the convenience of the attending physician. One physician in a teaching hospital has stated that by inducing labor, the deliveries do not interfere with office hours. If any obstetrician can determine just how many hours after rupture of the membranes a patient will deliver, his prophetic acumen in obstetric matters is indeed exceptional.

The induction of labor, when the termination of pregnancy is imperative or advisable in the interests of the mother or infant, is an important and recognized obstetric procedure. The most common maternal complication requiring the termination of pregnancy is pre-eclamptic tox-

emia. Other systemic conditions which may require the termination of pregnancy at or before term are diabetes, nephritis, pyelonephritis, and rarely heart disease. In certain cases of placenta previa and premature separation of the placenta, induction of labor by rupture of the membranes has a definite place. These instances are usually in cases of multiparous women with marginal placenta previa or less serious forms of placental separation, where effacement of the cervix is present and delivery is expected to be easy.

There are occasional relative indications for the induction of labor. Such an instance may be in the case of a patient who has a history of precipitous labors, and lives a long distance from the hospital. Here retainly the prerequisite conditions for the procedure must be present. These are generally considered to be: (1) cephalic presentation and no cephalopelvic disproportion; (2) pregnancy at term; (3) engagement of the presenting part; (4) effacement of the cervix.

The most reliable method of inducing labor is by rupture of the fetal membranes. This must be done without displacing the presenting part, and under surgically sterile conditions which are not present in the physician's office. Following rupture of the membranes, pitocin may be administered slowly and under careful observation. If the pregnancy is at term, labor may be started by catharsis with castor oil. This is the safest, but least reliable method of inducing labor. Also at term, labor may in some instances be induced by the intravenous injection of a dilute solution of pitocin without rupture of the membranes. Induction of labor by gauze packing, bougies, bags and catheters has no place in modern obstetrics.

Although a few years ago there were several advocates of elective induction of labor in uncomplicated pregnancy, for the satisfaction of the patient or convenience of the doctor, the more recent trend seems to reflect better obstetric judgment. Many hospitals quite properly require consultation prior to the induction of labor.

In certain cases, especially preeclamptic toxemia, termination of the pregnancy may be a life-saving procedure. Here the decision to induce labor or deliver the patient by section is to be determined by other obstetric conditions. The stage of the pregnancy, the parity of the patient,

the condition of the cervix, the presentation and presence or absence of cephalopelvic disproportion are all factors in determining the method of terminating the pregnancy.

In this connection, it is well to remember that the farther the pregnancy is from term, the longer will be the latent period from the time of the rupture of membranes to the onset of labor. Many series of a few hundred cases have been reported without maternal complications or increased fetal loss following elective induction of labor by rupture of the membranes. It is true that in normal pregnancy one could do several hundreds of sections without serious maternal complications and with a low fetal mortality. But who would advocate routine section even by the most expert obstetrician at term for convenience of the patient or the physician? We have personally observed four cases where the infant was lost, because of prolapse of the cord or prematurity, and one case of puerperal infection following ill advised rupture of the membranes for the elective induction of labor. Elective induction of labor in the normally pregnant woman properly should be considered meddling obstetrics and not a practice to be used by the physician to enhance his obstetric prowess.

BLUE SHIELD PROGRESS

SOMETIME this summer Mutual Medical Insurance will be starting on its second million. The total number of participants at the end of May was 979,352; and at the present rate of increase a million members will soon be enjoying the protection of the Indiana Blue Shield plan.

The growth of "The Doctors' Plan" has been vigorous since its organization; and it continues to develop at about the same rate as the other large plans of the United States. Mutual Medical is now seventh in size and has maintained this standing for some time. The six plans which exceed it in size are serving larger populations and have been in business longer.

Recently the 26 millionth national Blue

Shield member was enrolled. This was accomplished at a special ceremony before the House of Delegates of the A.M.A. during their meeting in New York City. It is interesting that this national milestone should be passed at approximately the same time the Indiana plan looks forward to enrolling its member No. 1,000,000.

Progress in Mutual Medical does not depend on size alone. The financial structure of this great undertaking was carefully constructed, and has been and is being most carefully guarded. Adequate reserves have been built up and, more important than this, the percentage of income which is disbursed for operating expenses always has been held to a low and reasonable figure.

Blue Shield progress is always evidenced by

the new and improved contracts and plans which are offered to groups and to individuals. Planning of improvements is a continuous process, carried out by Mutual Medical, by its Board of Directors and assisted by the Indiana State Medical Association. As

actuarial experience is gained by pilot plans, changes are suggested and studied with a view to constantly bettering the coverage which means so much to Hoosiers in providing a cushion for the financial shocks of illness and injury.

MEDICAL SOCIETY SPEAKERS BUREAU

VANDERBURGH County Medical Society has published and distributed recently a folder of information on their speakers bureau. The folder has been mailed to about 350 organizations in the county. A wide variety of medical subjects is listed, and advice on how to obtain speakers is set forth. Its pur-

pose as announced is to "present a well-rounded program of accurate, up-to-date and interesting information on health and medical subjects". The wide range of subject material would indicate that many individual members of the Vanderburgh Society have cooperated in organizing talks for lay organizations.

PRECEPTORSHIP PROGRAM STIMULATES INTEREST

A NEWLY FORMED preceptorship plan in which eight students from the University of Oregon Medical School participated last summer appears to have been a marked success.

In a report filed with the Medical School Dean by senior student J. Allan Henderson, it was pointed out that physicians in Oregon who helped the students gain a practical understanding of general practice in small communities, were cordial, enthusiastic and extremely interested. The preceptorship plan—while far from new to medical education—was something new in Oregon last year. Sponsored by the Medical School's local society of the Student American Medical Association with the approval and cooperation of the School's administration and the Oregon State Medical Society, it offers a student the opportunity of spending the summer between his junior and senior year assisting and observing the work of an interested physician in private practice somewhere in the state.

After the plan was formulated last spring

and approval had been given, a letter was sent out from the Dean to all general practitioners in Oregon announcing the idea and asking their help. Many more doctors in Oregon offered preceptorship openings than there were students available to fill the requests. Most students work at many odd jobs during the summer months in order to help finance their medical education and thus were unable to participate in the preceptorship plan.

At this time, the program as developed by the local student AMA society is informal and purely voluntary and is arranged by the students themselves. It is not a part of the Medical School curriculum and no credits are received.

From comprehensive, individual reports compiled by each of the eight men who participated in the preceptorship program, the following general information is of interest and indicates the value of the plan:

Locations and Physicians: In general, the towns had a population of a few thousand with a small (10-60) bed general hospital. The

majority of Preceptors were general practitioners.

Remuneration: This varied from "room and board" to \$250.00 per month.

Living Quarters: Quarters were furnished or easily available for either single or married students.

Student's Position: The students were, in general, a respected assistant to the physician and were given an opportunity to perform a wide variety of functions within the limitations of their capacity.

Experience: The students reported an opportunity to observe and receive instruction in the numerous medical and surgical problems which confront the general physician in his daily practice. This included emergencies, general surgery, obstetrics, orthopedics, physical examinations, and laboratory and radiographic technique.

Preceptor's Attitude: The students all agreed that the physicians were cordial, enthusiastic and interested. Many times they were patient in explanation and demonstration despite a demanding schedule. Some had definite teach-

ing programs in mind and patterned the work accordingly.

Value to the Student: The eight medical students listed seven separate areas in which they had gained much valuable experience:

1. It was an opportunity to see general practice.
2. It offered opportunity to observe the practice of medicine in a small community, away from large hospitals and clinics and extensive laboratory facilities.
3. It gave practical training in hospital and office techniques.
4. It was an excellent introduction to medical economics.
5. The experience of the summer's work has proved to be a great stimulus of interest to the students who are now in their senior year.
6. All students received instruction in and had an opportunity to observe "The Art of Medicine."

—The Bulletin

Multnomah County Medical Society

Medical Panorama *by the* ASSOCIATE EDITOR

PRETTY IS AS PRETTY DOES

The *Weekly Bulletin* of the Jackson County (Mo.) Medical Society for March 21, 1953, contains an editorial by Dr. G. W. Robinson, Jr., which contains grass-roots, down-to-earth, heard-before, but not-well-remembered wisdom for practicing physicians. We will quote first and comment after:

The medical profession spends millions of dollars each year on education and public relations. Some is spent directly through the A. M. A., the state and the county medical societies and by the several specialty societies. Some is spent by the drug houses, the hospitals, and the medical schools. The physicians are participants in these latter expenditures, even though they do not finance them out of their own pockets.

* * * *

Industry is a long way ahead of us in these matters, and by trial and error has learned some

things that we, in turn, can learn from them. The railroads found that all the "ads" and radio programs accomplished nothing in the face of surly and unaccommodating red caps, porters and conductors. A great department store was throwing away thousands of dollars in advertising because the clerks were completely unaccommodating. A manufacturer could not build up good will through all methods put together as fast as his telephone operator tore it down.

* * * *

Our profession is a rather closely knit group. Not only do the physicians rise and fall together in public opinion, but all of our co-workers are considered to be part of the team, and what one does affects all. We hear something like this once in a while: "What are these doctors thinking of? I called one and I never heard such a snip as his office girl." Study this carefully, "Doctors" . . . "one girl." All suffer from the misdeeds of one.

Physicians, their co-workers, their families and all hospital employees should try to build up good will every time they come in contact with people, either officially in their working capacities, or unofficially in their social lives.

We build good or bad public relations by the way we answer the 'phone at 2:00 a.m.; by the way our wives answer it outside of office hours and the interest she takes in the sick person at the other end of the line; by the type of care our patients receive in our hospitals and through our receptionists, office nurses and technicians.

* * * *

The harder we all work being nice to people, the more effective will be the results of the millions we spend each year for public education.

G. Wilse Robinson, Jr.

This editorial comes from Kansas City, which, no doubt, is as blasé as any other large community, yet they can produce and publish such fundamental and practical ideas and points-of-view as you have just read. We are every bit as aware as our reader that one of the doctor's most difficult feats is that of finding ancillary personnel who can and will "meet the public" in pleasing ways; yet the said doctor must accomplish this and must keep checking *himself* and his helpers if this problem is to be licked.

A BOOST WE CAN USE

The following clipping, printed as found in the *Detroit Medical News* for March 23, 1953, needs no comment, but merits your perusal (reading time 20 to 30 seconds):

LET'S THINK

Our confidence in the medical profession is not shaken by the controversy among doctors about who and how many of them are dishonest fee-splitters

and "ghost surgeons." The medical profession has done more than any other for humanity and will continue in this mighty service.

The Gospel of Christianity was not despoiled because eight and one-third per cent of Jesus' disciples was traitorous, selfish and mercenary. Cheer up, doctors! Your percentage of badness is only about 0.001.

By Arthur Maxson Smith

—Reprinted from The Romeo Observer Press.



Advice to the thin: Don't eat fast!

Advice to the fat: Don't eat! Fast!



President's Page



FELLOW MEMBERS OF I.S.M.A.:

FOR several years government agencies such as Boards of Health and component units of the National Tuberculosis Association have been conducting mass X-ray surveys. It is evident from these surveys that the average American is not on sociable terms with active pulmonary tuberculosis. Therefore, the X-raying of the entire population annually would be a colossal job and prohibitive in cost. To date, most mass surveys have not exhibited a sufficient yield of cases to warrant the cost, but the survey of those groups which have a high incidence of tuberculosis does reveal more active cases. Those groups which give a high incidence of tuberculosis are food handlers, tavern workers, all patients who are admitted to hospitals, people who reside in mental hospitals, jails, and the slum areas.

It has been suggested by some local tuberculosis associations that they be permitted to X-ray school personnel at less cost on a 70 mm. film. In the first place, this is not considered a diagnostic film. Besides, for a tuberculosis association to X-ray school personnel involves an infringement upon the private practice of medicine. It is a violation of the National Tuberculosis Association Seal Sale Contract which states, "Christmas Seal Funds may be used to encourage and promote the establishment and the support from public funds, or other sources, of services and facilities for case finding, diagnosis, treatment, and rehabilitation of the tuberculous. Transfer to public support must be made as soon as the value of these services has been accepted as a public responsibility." Thus a local tuberculosis association should transfer the X-raying of all individuals, who can afford X-rays, to already established facilities as soon as possible. The State of Indiana provides money through their township trustees and the school boards for the X-raying of its school personnel every three years, which furnishes a sufficient check on the incidence in this group. These X-rays have been made in clinics, hospitals, and physicians' offices on 14 x 17 diagnostic films. The Indiana State Roentgen Society suggested a minimum charge of \$5.00 for these X-rays. This is a noble gesture on the part of the physician to aid case finding.

Teachers represent a group who are in a position to educate young people to become X-ray conscious. They can discuss the symptoms of tuberculosis, and can urge everyone to consult their family physicians early in the light of said symptoms. And, by using themselves as examples, they teach their pupils not to rely on government facilities or tuberculosis associations for medical diagnosis and care. Teachers are obligated to encourage the youth of America and, as I have said elsewhere, to become self-reliant and irreproachable about frugality and economic independence.

In the hurly-burly of human events, one unwarily fails to realize that the promotion of an M-film survey might heighten the socialistic waves which are rolling over our democracy. This statement is applicable at least in part to many other health, hospital, and welfare promotions, even medical schools.

The future program of the National Tuberculosis Association advocates as one of its major objectives, more support from private physicians in order to decrease morbidity and mortality rates. How can one do this conscientiously

by trespassing on the free enterprise of the medical profession? If tuberculosis associations continue to confine their surveys to groups which do not frequent X-ray laboratories, clinics, physicians, and hospitals, they will continue the same ethical objectives in vogue prior to the popularity of chest X-rays. Such surveys as the X-ray survey and the diabetic survey which might be offered to the public are excellent for calling attention to the status of affairs, and to awaken the people to think about such diseases, but after the survey has accomplished its purpose, such work should be turned over to the medical profession for implementation.

The Indiana Roentgen Society adopted a resolution which indicates its disapproval of X-raying school personnel by the photo-fluorographic method. And you will infer from the previous remarks that objections are not limited always to the method but to the policy of some lay-health organizations which are inclined to pressure physicians as to what to do. On the other hand, physicians can offset the inclination of those who inadvertently desire to infringe upon the private practice of medicine by ordering routine chest X-rays on all hospital admissions. These could be taken on any size film if hospitals wish to do their part in finding early tuberculosis. The charge should not exceed two dollars. If the patient requires a large film the regular charge would be in order. But physicians are prone not to order routine chest films, and rightly so, as they do not wish to increase the patient's already too high hospital expense. This might be remedied if hospitals included in their daily room rate a "few incidentals of good will" gratis, such as aspirin, soda bicarbonate, sulphur drugs, and milk of magnesia. Then, the physician's inclination toward ordering a survey chest film might be more ductile.

Hospitals, long noted for charity, but in recent years seemingly imbued with the opportunist's idea for profit, should assume responsibility for X-raying the chest of all admissions. Twelve million adults are admitted to hospitals during a year. Routine chest X-rays offer protection to all hospital personnel, as well as to those patients who do not harbor a pulmonary lesion. If all hospitals performed this procedure routinely, the physician and the tuberculosis association certainly could agree on a policy of X-raying the groups which possess a high incidence of active and inactive tuberculous infection. And, if the Tuberculosis Associations live up to the tenets of their Seal Sale Contract,* ultimately all X-rays and other methods of case-finding will be handled by the medical profession. Thus the Tuberculosis Association can return to its original role as an educational organization.

Paul D. Grimm M.D.

P. S.: "Men judge by the complexion of the sky,
The state and inclination of the day."

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

TAX-FREE RETIREMENT PLANS

Millions of Americans on earned incomes are at a disadvantage, under the U. S. tax laws, in saving for their old age. They include the self-employed and salaried workers not covered by corporation retirement programs. They are victims of a kind of legislative discrimination that should be corrected, and several bills are pending in Congress to remedy the situation.

A corporation can set aside retirement funds for its employees and, for tax purposes, charge it to the cost of doing business. This means that a corporation under present tax schedules may accumulate retirement funds for all its employees and treat it as any other operating expense. But workers not covered by pension plans get no such tax relief on funds they may set aside for themselves for retirement, and neither do professional men. Whatever they save, it is subject to the full tax.

In the end, the only encouragement the man who earns his income gets from the government is social security, and a large number of self-employed professional men are excluded even from that.

President Eisenhower said during the campaign: "There are over ten million workers who cannot take advantage of these tax-relief provisions now offered to corporations and their employees. . . . I think something ought to be done to help these people to help themselves by allowing a reasonable tax deduction for money put aside by them for their own savings."

Bills introduced by Rep. Jenkins of Ohio and Rep. Keogh of New York are now before Congress, and would provide that:

1. Anyone not covered by one of several kinds of retirement funds may pay each year to a "restricted retirement fund" an amount up to ten per cent of his earned net income, with an annual ceiling on such payments of \$7,500. Or he may purchase a "restricted annuity contract" from an insurance company, with premiums subject to the same limitations.

2. For tax purposes, amounts so paid can be excluded from gross income.

3. If, in any year, less than the allowable maximum is paid in, the difference may be made up at any time within the following five years.

4. Individuals over 55 when the measure goes into effect may contribute somewhat larger amounts.

5. Payments from the fund may not begin before

65 (earlier in the event of a permanent disability). They are taxable in full as ordinary income. If, however, they are drawn out in a lump sum after five years' accumulation, they are subject to a capital-gains tax.

The Truman administration opposed a measure similar to the Jenkins and Keogh bills. Its objections were based on an estimated loss of a billion dollars a year in government revenue. It also objected that the proposal appeared to discriminate against other forms of saving.

There would be some revenue loss to the government but it should be possible to limit this loss to an amount that would not be serious. The need for all citizens to have a tax-free right to a retirement plan is paramount.

—*Kokomo Tribune.*

COMPULSORY TB TREATMENT

The senate public welfare committee is to hold hearings next week on the Drach bills for the compulsory treatment of tuberculosis patients and examination of suspected tuberculars. The bills have wide bipartisan sponsorship.

Sen. Drach, in introducing the bills, pointed out that, for the first time, Illinois has sufficient free facilities for treatment of tuberculosis to make such a program as he proposes practicable. Until recently, even the people who wanted treatment had a hard time getting it in Chicago.

The bills provide that public health officers may require persons whom they suspect of having tuberculosis to be examined by physicians. If a person with an active case refuses treatment, he may be committed to a public sanitarium. Presumably the bills will also give health authorities power to prevent patients leaving such institutions against medical advice before their cases are arrested.

Tuberculosis is a contagious disease. The patient who neglects treatment of an active case is just as much a menace to the public generally and to members of his own family in particular as one who breaks quarantine for any other contagious disease. Health officers now have power to quarantine tuberculosis patients, but almost never use it because of the danger of infection to the people with whom they live. Institutional treatment, as provided by the Drach bills, is preferable.

—*Chicago Tribune.*

News Notes



Pictured above is the reunion picture of the Class of 1903, Medical College of Indiana. In the foreground in wheelchair is Dr. E. F. Kratzer*, Kokomo. From left to right in first row are C. W. Atkinson, Boswell; E. F. Kiser, Indianapolis; R. D. Varner, Paris, Illinois; F. S. Crockett, Lafayette; Harry J. Weil, Indianapolis, and C. W. Combs, Terre Haute. Also from left to right, those in the second row are W. S. Coleman, Carthage; K. I. Jeffries, Indianapolis; E. B. Moser, Windfall; Murray N. Hadley, Indianapolis; and P. S. Johnson, Richmond.

The Golden Jubilee reunion of the class of 1903 of the Medical College of Indiana was held at the Riley Hospital, Indianapolis, May 17, 1953. There were 12 members in attendance: Drs. C. W. Atkinson, Boswell, W. S. Coleman, Carthage, C. N. Combs, Terre Haute, F. S. Crockett, Lafayette, M. N. Hadley and K. I. Jeffries, Indianapolis, P. S. Johnson, Richmond, E. F. Kiser, Indianapolis, E. F. Kratzer, Kokomo, E. B. Moser, Windfall, R. D. Varner, Paris, Ill., and H. J. Weil of Indianapolis. Of this number, 10 have been in active practice continuously for the 50 years. The other seven survivors† are retired from practice.

On April 17, 1903, 77 young men and one young woman departed from the old college building on North Senate Ave. and by two years

missed being the last class to graduate from the old Medical College of Indiana. That night, they received their diplomas signed by Addison Harris, President of the University of Indianapolis, and by 26 professors of the College of Medicine. Of these 26, only 2 remain today, John W. Sluss, and Richard Schaefer. The commencement was held in the English Hotel, and the address was given by

* Dr. Kratzer's death occurred two weeks after this picture was taken.

† The five who were unable to attend included Drs. H. M. Schultz, Logansport, E. E. Rose, Indianapolis, A. C. Newby, Sheridan, A. H. Miller, Russiaville, and W. W. Kemper, Bremen, Ohio.

William Lowe Bryan, President of Indiana University.

The class of 1903 has a strong sentimental loyalty and is the oldest class that holds regular reunions, with a total of 15. Beginning with the twentieth year, reunions were held every 5 years on three occasions and then every two years, and since 1949 every year. From now on the reunions will be held at the annual sessions of the Indiana State Medical Association together with the other members of the Fifty Year group.

This class was the last one to be admitted to practice without taking the state board examination. Only a few had previous college education, and not all had finished high school. Fewer, still, served any internship, and the class was sent out into general practice without the finished education provided and demanded at the present time.

The mortality of the class was 12 in the first 20 years, 22 in the second 20 years, and 25 in the last decade. This class may be called the Presidential Class, as three members, Drs. Combs, Crockett and Jesse Ferrell (deceased) have served as President of the Indiana State Medical Association, and two others, Drs. Kiser and Hadley, as President of the Indianapolis Medical Society, which is the largest unit of the State Association. One member was elected as Practitioner of the Year, chosen from the whole state of Indiana in 1949, which is a rare honor. Three members have been delegates to the American Medical Association, one for the last 27 years, and with such ability that he has been chairman of the committee on Rural Medical Service for the past six years.

A comparison with the cost of medical education today may be made by extracts from an expense account kept by one member of the class who was a junior at the time. The college fees for the year were \$75.00, plus \$3.00 each for clinic tickets to the City and St. Vincent's Hospitals, and a dissecting fee of \$2.50. The student was required to purchase nine medical books at an average cost of \$4.00 each. His room was \$5.00 a month and board cost \$2.75 a week. Clothing consisted of one suit, \$15.00, one overcoat, \$15.00, a pair of shoes, \$3.00, and a hat, \$2.00. One expense, but not required, was a microscope, \$70.00. This left him with \$1.00 a day for

laundry, street car tickets, several tickets to the English Theater at 25c each, and miscellaneous extravagances for the seven month school year. This was a total cost of just under \$500.00.

—Contributed

Daughter of Hoosier Congressman with A.M.A.

Rosetta Beamer, daughter of John V. Beamer, representative in Congress from the Fifth Indiana district, will be employed in the national headquarters of the American Medical Association in Chicago following her graduation in June from Northwestern University. Miss Beamer's home is in Wabash.

Dr. George M. Faile, who is serving a fellowship in surgery at Welborn Clinic, Evansville, has been appointed to overseas missionary work by the Southern Baptist church and will leave soon for Nigeria. He is a graduate of Emory University School of Medicine, Atlanta.

Dr. Robert L. Witham, who has been in general practice in Culver since his discharge from the army in 1947, has closed his office and moved to Indianapolis where he has accepted a residency appointment at I. U. Medical Center.

Dr. Myron L. Habegger, who has practiced in Berne for 20 years, left early in June for Cocoa, Florida, where he will be associated at 12 Magnolia Street, with Dr. Charles Russell. Doctor Habegger served as secretary of Twelfth District Medical Society last year.

On July 1, **Dr. Robert L. Boze** will open his practice in Berne, his home town. He will occupy the offices being vacated by Doctor Habegger. Doctor Boze is a graduate of Indiana University School of Medicine and is just completing his internship at Lutheran Hospital, Fort Wayne.

Dr. Crimm Talks to Ohio State, Lake County TB Groups

Paul D. Crimm, M.D., president of the Indiana State Medical Association, was the principal speaker at the Ohio State Tuberculosis Association's annual meeting on May 14 in Columbus. He spoke on "Civic and Medical Problems of a Tuberculosis Association". On May 22 Doctor Crimm discussed the same subject when he was guest speaker at a meeting of the Lake County Tuberculosis Association in Gary. Dr. Crimm is administrator of Boehne Tuberculosis Hospital, Evansville.

Dr. L. S. Bailey, Zionsville, who has practiced in the same location since 1930, recently purchased a residence at Oak and Elm Streets, Zionsville, and has moved his office to that location.

Revised Physician's Handbook Distributed by Heart Association

A completely revised and greatly expanded edition of a unique medical handbook, "Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Blood Vessels," has been prepared by the New York Heart Association, and is now being offered to general practitioners, cardiologists, medical students, and interns throughout the country by the American Heart Association and its affiliates. Some entirely new concepts and viewpoints in the cardiovascular field are included in the latest edition. The previous edition was published in 1939.

The illustrated handbook is intended primarily to clarify and standardize the language used by the medical profession in diagnosing cardiovascular diseases.

For the first time, the handbook includes a section on diseases of the peripheral vessels, which comprise the smaller arteries, capillaries, and veins. This group of diseases has only recently come to be recognized widely as an entity in the cardiovascular field and as an important cause of disability and death.

"Nomenclature and Criteria" may be purchased through heart associations or book stores at \$4.95 a copy.

Anniversary Revives Story of Service to I.S.M.A.

An Anderson doctor, Maynard A. Austin, and his wife recently celebrated their golden wedding anniversary. The April 29 family dinner was the occasion for the recounting of many experiences of the busy Anderson couple during their years of service to organized medicine in Indiana.



Dr. Austin

From the time Doctor Austin opened his office in Madison county in 1900 he was active in affairs of his profession. A graduate of Rush Medical College, Chicago, the veteran Anderson physician helped organize the faculty of the Indiana University School of Medicine in 1908 and taught surgical pathology at the school for four years. He was secretary of Madison County Medical Society 25 years, secretary of the Eighth District Medical Society 6 years, Councillor for the Eighth Medical District 18 years, chairman of the Council from 1937 to 1941, and was elected President of the Indiana State Medical Association, serving during 1942.

Mrs. Austin organized one of the first Auxiliaries in the state in 1927, serving as Madison County Auxiliary president in 1928 and 1929. In 1930 she was named President of the Women's Auxiliary to the Indiana State Medical Association and in 1932 became state treasurer of the Auxiliary.

Dr. George L. Compton, Tipton, has established new offices at 219 North Independence Street in a recently constructed modern building which he will share with M. G. Smith, D.D.S. Doctor Compton has been in practice in Tipton since 1943.

Dr. Carroll Boyle and **Dr. Ivan Gailey**, who are interning at Gary Methodist Hospital, will locate in Poseyville where they have purchased a building to remodel into office space.

Criteria for Issuing of Gamma Globulin for Polio

The following technical bulletin has been received by all Indiana doctors from the Indiana State Board of Health:

The following criteria were established at a joint meeting of the Committee on Infantile Paralysis of the Indiana State Medical Association, members of the staff of the Indiana University School of Medicine, and hospital representatives of the Indiana State Health Officers' Association, and members of the Indiana State Board of Health.

1. Gamma globulin will not be given except to immediate family contacts under fifteen years of age.
2. Gamma globulin may be used for pregnant women of any age who have not had polio.

The supply of gamma globulin for polio prophylaxis is so limited that there will be many requests that cannot be filled. Physicians are urged to weigh carefully the indications for gamma globulin in any particular case. It must be remembered that many individuals will desire globulin to whom it cannot be given. In this regard it should be pointed out to the patients, if any long time interval has occurred between the onset of the original case in the family, that the likelihood of any value to other members of the family is doubtful.

Dr. Kermit Perrin was elected president of the Lutheran Hospital staff, Fort Wayne, at the annual election May 12. **Dr. A. P. Hattendorf** was named president-elect; **Dr. T. O. Meyer**, secretary; and **Dr. Charles Dancer**, treasurer. Chosen for the executive board were **Drs. Wayne R. Glock**, **Ralph Elston**, **Milton Popp** and **E. M. Hoetzer**.

Citizens of Pekin are raising a \$15,000 fund through the Pekin Community Betterment organization and the Pekin Grange to provide a modern office for **Dr. William Paynter**, a graduate of Indiana University School of Medicine, who will complete his internship at a Lafayette hospital July 15. He plans to begin practice in the new office August 1. Doctor Paynter is a native of Salem.

Dr. Thomas C. Brown, who has been in general practice in Delphi for five years, left July 1 for Houston, Texas, where he has accepted a residency at Hermann Hospital. He will specialize in radiology. He resigned as Carroll County coroner and as Delphi city health officer before leaving.

Dr. Robert M. Sesse, Cleveland, Ohio, purchased Doctor Brown's office equipment and assumed his practice July 1. He is a graduate of Western Reserve University School of Medicine. Doctor Sesse is a personal friend of Dr. John Wagoner, Delphi.

AMA Publishes Revised Health Insurance Booklet

The Seventh annual revision of the health insurance brochure published by the Council on Medical Service and its Committee on Prepayment Medical and Hospital Service now is available to physicians and allied groups. In this booklet—"Voluntary Prepayment Medical Benefit Plans"—each plan is described by summary of benefits, enrollment at the end of 1952 and other pertinent data. Separate sections list plans by type of sponsorship. Also identified are plans which have been granted the Council's seal of acceptance. One section is devoted to Canadian plans which have been organized or approved by the provincial branches of the Canadian Medical Association. In addition, other types of programs are described to give examples of voluntary methods of insuring some of the costs incident to health care. Single copies are available, without charge, from the Council.

Dr. Joseph E. Smadel, son of the late Dr. Joseph W. Smadel, Vincennes, was awarded the Howard Ricketts medal at the University of Chicago, May 17, in recognition of his research work at Walter Reed Army Medical Center, Washington, D. C. Doctor Smadel discovered the benefit of antibiotic drugs in the treatment of typhus, the disease from which Doctor Ricketts died in 1910.

Scholarships and Loans Open for Student Nurses

There are 55 scholarships and 27 loans available for young women who want to take a three year basic course in nurse's training, the Indiana State Nurses Association announces.

While registrations are being taken now for the classes which begin in August and September, there still are opportunities for girls to receive help in financing their course.

State association officials, said there is no opportunity for girls to work their way through school during this course, since hours are such that it is impossible to take outside jobs. The scholarships cover tuition, books, uniforms, even the graduation pin. The girl needs to supply only her incidental expense money.

Since each school of nursing has certain basic requirements, it is suggested that applicants for scholarships confer with the director of the school in which she is interested. Information also is available in the district nurse association offices.

Major Robert Wm. Harger (ANGUS (MC)), Indianapolis, recently returned from a second tour of active duty with the U. S. Air Force. He was recalled from the Indiana Air National Guard in August, 1951, and until May of this year was assigned as Chief, EENT Section, USAF Hospital, Bolling AFB, Headquarters Command, Washington, D.C.

Doctor Harger has opened an office for the practice of ophthalmology in the Hume Mansur building, Indianapolis. He is a 1945 graduate of I. U. School of Medicine, interned at Indianapolis General Hospital in 1946, took Basic Ophthalmology at Wayne College of Medicine, Detroit, in 1949, and served a residency in ophthalmology at I. U. Medical Center in 1951.

Guthrie Y. Graves, M.D., Bowling Green surgeon and gynecologist, has been named president of Kentucky State Medical Association, to fill the unexpired term of R. Haynes Barr, M.D., Owensboro, who died on May 5. President-elect J. Duffy Hancock, M.D., Louisville, will become president on September 24.

Dr. Robert A. Smith, New Castle, has been named president of the Indiana Academy of Ophthalmology and Otolaryngology. Also elected at the recent state meeting of the group in McCormick's Creek State Park were **Dr. C. P. Clark**, Indianapolis, president-elect; **Dr. Raymond Calvert**, Lafayette, vice-president; and **Dr. John Swan**, Indianapolis, secretary-treasurer.

American College of Chest Physicians Elects Dr. Stygall

Dr. James H. Stygall, Indianapolis, was elected to the first vice-presidency of the American College of Chest Physicians at annual convention held in New York, May 28-31. Others from Indiana who attended the meeting included Drs. John V. Thompson, Edwin R. Eaton, Indianapolis, J. V. Pace, New Albany, Thomas R. Owens, Muncie, and George D. Buckner, Fort Wayne.

Wabash Doctor Takes Post at Philadelphia

Dr. Arthur P. Rhamy, Wabash physician and surgeon for the last 19 years, has accepted a position as chief resident in urology at Philadelphia General Hospital after completing post-graduate work at the University of Pennsylvania. The appointment was effective July 1 and is for two years.

Doctor Rhamy received his medical degree from Emory University School of Medicine, Atlanta, following which he taught anatomy at Emory for six years and was assistant professor of anatomy at Tulane University of Louisiana School of Medicine, New Orleans, for the 1933-34 school year, returning to his native county in Indiana to practice that year.

He was the first medical volunteer from Wabash County in World War II and served as commander in the Navy in the Pacific theatre.

Dr. D. C. Emenhiser, New Haven, has reported for active duty as a lieutenant-colonel in the Army Medical Corps at San Antonio, Texas. Doctor Emenhiser, a graduate of I. U.

School of Medicine, has practiced for 10 years in New Haven. Following his first three years in practice he went to the University of Pennsylvania, Philadelphia, for a two year residency in surgery. Dr. Edwin E. Stumpf, who has been in practice with him, will remain in the same office in New Haven.

Twenty-first Annual Assembly of the **Omaha Mid-West Clinical Society** has been scheduled for October 26-29 in the Hotel Paxton, Omaha, with a large list of distinguished out of state speakers on the program in addition to faculty members of Creighton and Nebraska University Schools of Medicine.

The **New York Academy of Medicine** has issued programs for the Twenty-sixth Graduate Fortnight to be held October 19 through October 30. Six morning panels, afternoon hospital clinics and 20 evening lectures, together with all scientific exhibits, will cover various phases of "Disorders of the Blood and Blood-Forming Organs". Full details may be obtained from Secretary, Graduate Fortnight, 2 East 103 Street, New York 29, New York.

At the recent Thirtieth Annual Meeting of the **Indiana State Medical, Dental and Pharmaceutical Association** in Gary the following officers were elected to serve during the coming year: President, Edward L. C. Broomes, M.D., East Chicago; vice-president, H. Herman Sloss, M.D., Terre Haute; treasurer, Frank W. Chowning, D.D.S.; secretary, Dennis A. Bethea, M.D., Hammond.

Dr. Robert P. Dimmitt, who has just completed his internship at Indianapolis General Hospital, began the practice of medicine in Boonville July 1. He is associated with Dr. Jack H. Purcell and will continue there after Doctor Purcell's expected induction into the army. Doctor Dimmitt, a native of Evansville, is a graduate of I. U. School of Medicine and a World War II veteran.

Dr. H. Allison Miller, Marion physician and surgeon since 1931, has been named president of the board of Marion General Hospital. He has been a member of the board for 16 years.

Esophageal Speech Institute At Cleveland August 10-16

An institute on teaching and improving esophageal speech will be held in Cleveland at the Cleveland Hearing and Speech Center, August 10 through August 16. Sponsors are the American Cancer Society, National Cancer Institute of Institutes of Health, the Office of Vocational Rehabilitation, Cleveland Otolaryngological Society, the Cleveland Academy of Medicine and the Western Reserve University School of Medicine.

Surgeons, speech pathologists and lay persons are invited to attend the sessions. Limited registration is necessary. Application should be mailed by July 15 to Warren H. Gardner, Ph.D., Program Chairman, 11206 Euclid Avenue, Cleveland 6, Ohio.

Dr. Norbert Weber, who has been in general practice in Fort Wayne since July, 1952, has closed his office and reported for duty at Fort Sam Houston, Texas, where he will serve as a first lieutenant in the Army Medical Corps. He is a graduate of Loyola University Medical School, Chicago, and interned at Mercy hospital, Toledo.

Dr. Kenneth L. Craft, Indianapolis, was one of the speakers at the recent annual meeting of the Pennsylvania Academy of Ophthalmology and Otolaryngology, held at Galen Hall, Wernersville, Pennsylvania, May 21-22-23. Dr. Craft's talk was on "Allergy of the Upper Respiratory Tract".

BULLETIN ON "DOCTOR DRAFT LAW"

Note: The following bulletin from the Council on National Emergency Medical Service of the American Medical Association was received July 1. Because of the vital importance of this information to many doctors throughout the state it is being printed in full below:

June 29, 1953.

Today the President signed Public Law 84, 83rd Congress, extending until July 1, 1955 a revised version of the "Doctor Draft Law". In view of the extensive interest in this measure, I would like to explain briefly the provisions of the new law.

Hearings were held last month in the House of Representatives and the Senate relative to H. R. 4495, 83rd Congress. A slightly different version of this bill was passed by the two legislative bodies thereby necessitating the appointment of a Conference Committee to resolve the differences between the two bills. The measure, as finally passed by the Congress and as signed by President, will:

- (1) Extend the effective date of the "Doctor Draft Law" until July 1, 1955;
- (2) Retain the maximum ages specified in existing law: Registration, age 50; Liability for induction, age 51;
- (3) Continue in effect the four priorities established by existing law with the following amendments:
 - (a) All service performed since September 16, 1940 as an officer or as an enlisted man, with certain exceptions which will be outlined later, will be credited as service. At the present time doctors in priorities 1 and 2 only receive credit for service performed "subsequent" to deferment or participation in a Navy V-12 or Army Specialized Training Program during World War II;
 - (b) The length of service required to qualify for priority 4 for doctors who were deferred or educated at government expense during World War II is reduced from 21 to 17 months. As a result of this provision a substantial number of doctors will be reclassified from priority 2 to priority 4;
 - (c) Establish the following new periods of service for men recalled to active duty or inducted pursuant to the "Doctor Draft Law":

<i>Previous Service</i>	<i>New Period of Duty</i>
9 months or less	24 months
9 to 12 months	21 months
12 to 15 months	18 months
15 to 21 months	15 months

- (d) Removes the liability for induction or recall to active duty, except in time of war or national emergency hereafter declared by Congress, for those men in

priority 4 who have had 21 months or more of service since September 16, 1940.

- (4) Define "active duty" and "active service" to include:
 - (a) Full-time duty in the active service of the United States since September 16, 1940 in the Army, Navy, Air Force, Marine Corps, Coast Guard or United States Public Health Service, including reserve components;
 - (b) Time spent during World War II in work of national importance by conscientious objectors;
 - (c) Service performed before September 2, 1945 in the Armed Forces of countries which were allies of the United States during World War II; and
 - (d) Service performed as a physician or dentist by United States citizens employed by the Panama Canal Health Department between September 16, 1940 and September 2, 1945.
- (5) Exclude from consideration as "active duty" periods spent in a Navy V-12 or Army Specialized Training Program; in a military internship, residency or senior student program; in military service for the sole purpose of undergoing a physical examination or while engaged in active duty for training entered into after June 29, 1953;
- (6) Authorize the appointment of medical officers in grades commensurate with their professional education, experience or ability. This section is intended to provide for uniform treatment with respect to the ranks of all doctors called to active duty irrespective of whether they had previous military service;
- (7) Continue until July 1, 1955 the authority to provide the "Special Pay" of \$100 per month for doctors in the Armed Forces. This section also extends the class of persons eligible for such pay to include veterinarians;
- (8) Authorize the commissioning of non-citizens of the United States as officers in the Armed Forces;
- (9) Terminate automatically, upon completion of 12 months or more of service subsequent to September 9, 1950, the reserve commissions of all physicians taken into service by operation of the "Doctor Draft Law". Upon completion of this same service medical reservists recalled to active duty will be given an opportunity to resign their commission. Such persons, whether registrants or reservists, shall not be liable thereafter for recall or reinduction except in time of war or national emergency hereafter declared by the Congress;
- (10) Reenact the present provisions of law which permit the deferment of those individuals who are essential to the national health, safety and interest;
- (11) Authorize the national, state and local medical advisory committees to the Selective Service System, in addition to their present authority, to make recommendations

with reference to the deferment of (a) registrants engaged in residency training, (b) those serving on faculties of medical and certain other schools and (c) those engaged in essential laboratory and clinical research;

- (12) Extend until July 1, 1955, the authority of the President to recall medical reservists to active duty involuntarily;
- (13) Be retroactive in effect. Those men already in uniform who would have benefited from the new changes in the law will, upon filing an application, be eligible for release from service as soon as possible and in no event later than 90 days after the effective date of the Act (June 29, 1953).

In considering the over-all effect of the new law it should be noted that the major changes involve greater recognition of prior military service. The result is that a particular registrant, by being able to take advantage of the various new provisions, may either (a) become exempt from liability for service, (b) be placed in a priority less vulnerable to immediate call, (c) be subject to a reduced term of service, or (d) effect a severance of military status within 90 days upon application or after the completion of his period of service by being either discharged or permitted to resign.

These amendments will remove many of the inequities which now exist. Many of the recommendations made by the American Medical Association in its testimony before the Armed Services Committees of the House of Representatives and the Senate were accepted. Those which were modified or rejected are:

- (1) The Association recommended that the liability for registration and call-up of veteran physicians in priority 4, as well as the involuntary recall of medical reservists in this category, be terminated as of July 1, 1953.

The law, as enacted, excuses from further liability those registrants and reservists in priority 4 with 21 months or more of service since September 16, 1940. This amounts to substantial acceptance of the Association's recommendation since between 85 and 90% of the physicians in priority 4 have 21 months or more of service.

- (2) The Association recommended that the second period of duty be limited to 12 months for a registrant or a reservist who had 12 or more months of previous service.

The law, as enacted, establishes a staggered period of service (see item 3 (c) above).

- (3) The Association recommended that all accrued or terminal leave as well as travel time be included in computing total active duty.

Such credit was not allowed. The Armed Services Committee of the House of Representatives indicated that the reduction from 21 to 17 months to qualify for priority 4 was intended to take care of inequities of this type.

- (4) The Association recommended that the reserve commissions of doctors called into service by operation of the "Doctor Draft Law" should not be vacated automatically upon completion of required service. It was the belief of the Association that doctors should be given the option of retaining or resigning their commissions. It was further recommended that reserve officers in the Navy and Marine Corps with service in World War II be permitted to resign their commissions immediately if they wished to do so.

The recommendations of the Association in this regard were not accepted.

- (5) The Association recommended that any extension of the "Doctor Draft Law" be limited to one year.

The law was extended for 2 years.

You will be interested to know that the Council on National Emergency Medical Service has authorized the preparation of a brief and simple brochure explaining the provisions of the new "Doctor Draft Law" as well as the pertinent administrative regulations of the Armed Forces and the Selective Service System. It is planned to circulate this booklet through state and county medical societies for the information and benefit of individual physicians. If there are any particular facets of this subject which you believe should be stressed, we would appreciate receiving your comments and suggestions.



A.M.A. WASHINGTON OFFICE NEWS

Dependent Care Commission Hears 30 Witnesses. After taking testimony from 30 witnesses in two day-long sessions, the Defense Department's Commission on Medical Care of Dependents of Military Personnel will draft recommendations. The 5-man commission's report will be turned over to the Secretary of Defense. Chairman of the commission is Harold G. Moulton, Ph.D. former president of Brookings Institution.

Testifying for American Medical Association, **Dr. Walter B. Martin**, a member of the Board of Trustees, said the Association strongly feels the question of the responsibility for military dependent care should be answered by Congress and not by administrative interpretations.

Dr. Richard Meiling, who served from 1949 to 1951 as assistant to the Secretary of Defense for medical and health affairs and is now associate dean of Ohio State University College of Medicine, also testified. Dr. Meiling said that for years funds for medical care of military dependents have been a "hidden item" of the various military budgets. He recommended that such funds be "carefully and honestly accounted for as are the funds of the Quartermaster Corps for food." He said a serviceman could have two options in the event Congress saw fit to provide by law "allowances for medical care, treatment and hospitalization." Depending on the local situation, his family would be eligible for (1) dependent care at sliding rates established by the Budget Bureau at facilities of military medical services where available and staffed, or (2) care to dependents through civilian channels with payment through such voluntary programs as Blue Shield and Blue Cross.

Civil Defense Issues Manual on Emergency Medical Treatment. A 69-page manual titled *Emergency Medical Treatment* has been published by Federal Civil Defense Administration to help doctors and other civil defense casualty workers treat large numbers of victims of enemy attacks on U. S. cities. The publication, which is available at Government Printing Office, Washington 25, D. C., for 25c a copy, is being distributed to state medical societies as well as state and local civil defense officials. Chapters deal with casualty services system, wounds, wound shock, burns, fractures, acute radiation syndrome, blood transfusion and saline in treatment of shock.

Volunteer Now, Army Advises Interns. The Army reminds the 3,000 or so physicians under 30 who are completing their internships or residencies this month that it may be to their advantage to volunteer for the Army Medical Service instead of waiting for a call through the doctor draft. The Army comments: "The physician who volunteers at least knows the exact date that he is to enter the Army. Also he will not lose out financially during the several months interim between the time his civilian training has been completed and the date he comes into the Army." Physicians interested in volunteering should contact the Army area headquarters in which they live.

Deaths

John F. Powell, M.D., a senior member of Indiana State Medical Association, died at his Greentown home June 5 after being seriously ill three months. He was 78, a life resident of Greentown, and a physician there for 56 years. Doctor Powell was an 1897 graduate of Medical College of Indiana at Indianapolis and was in general practice for many years, later becoming an optometrist.

Frank D. Martin, M.D., 62, Bedford specialist in ophthalmology and otolaryngology since 1919, died suddenly May 18. A native of Salem, Doctor Martin was graduated from Indiana University School of Medicine in 1914, after which he spent several years in Colombia, South America, as physician for a diamond mining firm. Returning to the United States, he practiced a short time in Kokomo before establishing his practice in Bedford. Doctor Martin was past president of Lawrence County Medical Society, and a member of both state and national medical associations. He served as a first lieutenant in the army medical corps during World War I.

Eugene F. Kratzer, M.D., 76, Kokomo, died June 1 in an Indianapolis hospital where he had been a patient for only a few days. He had attended the golden anniversary of his graduation from the Medical College of Indiana on May 17. Born in Howard county, Doctor Kratzer went to Peru for five years following his graduation and then practiced in Wawpecong for 40 years, going to Kokomo in 1948. He had been in retirement for two years. Doctor Kratzer was a member of Howard County Medical Society, and a senior member of Indiana State Medical Association.

Richard B. Nelson, M.D., 44, Hammond surgeon for the last 19 years, died in St. Margaret

Hospital in that city June 10 after suffering a heart attack. Born in Hammond, Doctor Nelson graduated from the Purdue School of Pharmacy, then used that profession to assist him in completing his work on his medical degree. He was graduated from Indiana University School of Medicine in 1933. He served his internship at St. Francis Hospital, Evanston. Doctor Nelson served for 44 months during World War II. He was a member of Lake County Medical Society, Indiana State and American Medical Association.

INDIANA STATE BOARD OF HEALTH
Division of Communicable Disease Control

MONTHLY REPORT—MAY 1953					
Disease	May 1953	April 1953	Mar. 1953	May 1952	May 1951
Animal Bites	427	161	78	—	—
Brucellosis	3	1	—	4	—
Chickenpox	511	513	819	356	156
Conjunctivitis	67	56	51	—	9
Diphtheria	3	3	1	9	6
Dysentery, Amebic	8	—	7	3	—
Dysentery, Unspecified	12	6	2	—	1
Food Infection	2	2	—	1	3
Impetigo	6	6	5	1	5
Infectious Diarrhea	2	2	5	3	—
Infectious Hepatitis	127	106	78	21	9
Infectious Mononucleosis	5	6	1	—	—
Influenza	61	224	596	9	38
Measles	2,198	813	908	2,000	648
Meningitis, Meningococcal	18	18	13	12	2
Other	5	—	2	3	6
Mumps	405	185	214	529	292
Paratyphoid Fever	1	—	—	—	—
Pneumonia	48	46	71	64	44
Polioomyelitis	12	11	3	5	1
Rabies in Animals	55	27	21	14	58
Rheumatic Fever	8	5	7	7	5
Scabies	3	2	5	—	—
Streptococcal Infections, incl. Erysipelas, Scarlet Fever, Septic Sore Throat	226	226	329	176	102
Tetanus	1	—	—	1	1
Tinea Capitis	20	8	27	1	—
Typhoid Fever	1	5	1	2	2
Vincent's Infection	4	5	4	—	1
Whooping Cough	49	21	27	29	135

Society Reports

INDIANA STATE MEDICAL ASSOCIATION EXECUTIVE COMMITTEE

May 24, 1953

Roll call showed the following present: James W. Denny, M.D.; Paul D. Crimm, M.D.; W. H. Howard, M.D.; E. R. Clarke, M.D.; Roy V. Meyers, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump, attorney; James A. Waggener, executive secretary, and R. J. Amick, field secretary.

Membership Report

Number of members May 23, 1953-----3,620*

Number of members May 23, 1952-----3,541

Gain over last year ----- 79

Number of members December 31, 1952---3,782

* Includes 125 in military service (gratis)

104—\$10.00 members (residents and interns)

227—senior members

65—members, dues remitted by Council

Number who have paid AMA dues:

1952-----3,663; 1953-----2,989

Headquarters Office

The field secretary, Mr. Amick, reported on the planning conferences he had attended for establishment of the regional school health programs, and the committee felt the headquarters office should urge physicians to attend these meetings.

The executive secretary reported that the field secretary, Mr. Bruce G. Nowlin, had been dismissed as of May 15.

By consent it was agreed that the headquarters office shall be closed on Saturdays during the months of June, July and August.

The executive secretary was given permission to accept the secretaryship of the Indiana Council for Children and Youth.

Treasurer's Office

The treasurer reported that the certificates of indebtedness had been reinvested in one-year government bonds, 2½ per cent, series B.

Statements of receipts and expenditures and report on the budget for April for the Association and

THE JOURNAL were approved.

The Journal

Report on advertising was approved by consent:

Total, May, 1952-----\$2,050.19

Total, May, 1953 ----- 2,072.65

Legislative Matters

National. The secretary reported that the resolution passed by the recent House of Delegates con-

cerning doctor draft legislation had been forwarded to the senators and representatives in Congress, and that acknowledgements had been received from them.

Dr. Clarke brought up the matter of the Reed-Keogh bill, and upon his motion, seconded by Dr. Denny, the committee went on record as favoring the passage of this bill and instructed the executive secretary to so notify the delegates and alternate delegates to the A.M.A. This matter is to be referred to the Council at its July meeting, with the recommendation that the Council adopt a similar motion and that the delegation from Indiana in Congress be informed of the Association's approval of this type of legislation.

Local. The executive secretary reported on the transmittal of the resolution passed by the recent House of Delegates concerning a study by state officials of means of increasing the enforcement of the Medical Practice Act, said resolution being directed to the Governor, the Attorney-general, and the Director of the Budget. A letter from the Governor's office was read acknowledging receipt of the resolution and stating that it would be referred to the Governor at the first opportunity.

1953 Annual Convention, French Lick, October 19, 20 and 21, 1953:

Report on sale of technical exhibit space was noted and approved. 66 booths sold to 61 companies for \$10,125.00; 1—\$175.00 space to be sold.

General Practitioner award. By consent, the committee agreed to give an award to the General Practitioner of the Year and upon motion of Drs. Denny and Howard, the committee decided to give a plaque this year instead of a picture.

Fifty-Year Club reception. By consent, it was agreed that the Fifty-Year Club reception would be held at the expense of the association.

Organization Matters

Request of the American Medical Association for an expression of the Indiana State Medical Association to a questionnaire prepared by them on osteopathy was accepted and the committee filled in the answers to the questions requested.

Liaison Committee with Indiana Association of Licensed Nursing Homes. Letter from Mr. Jerry Eastburg, president of the Indiana Association of Licensed Nursing Homes, was read in which he agreed to include the nursing group on a liaison committee and requesting a meeting of the Liaison Committee on June 22. Drs. James W. Denny, Cleon A. Nafe and J. William Wright, Sr., were named to represent the association on this committee.

Board of Appeals. A letter addressed to the Executive Committee from the Board of Appeals regarding a suggestion for the Board of Appeals to adjudicate and inspect medical testimony was read, and by consent reply is to be referred to the Council with the recommendation that the suggestions made by the Board of Appeals be approved.

The request for approval of the Indiana Association for Mental Health was read and approved by consent.

Renewal of subscription to The Shearon Legislative Service and the Washington Report on the Medical Sciences was approved by consent.

Letter from H. DeWitt Owen, administrator of the State Department of Public Welfare, in which he accepted the suggestion made and the resolution adopted at the April 26 meeting of the House of Delegates to establish a liaison committee for the purpose of studying the advisability of establishing a statewide fee schedule in welfare cases was read.

By consent, Dr. Richard P. Good of Kokomo, Dr. Russell J. Spivey of Indianapolis, Dr. E. S. Jones of Hammond, and Dr. E. L. Fitzsimmons of Evansville, were selected to represent the association and are to be notified of the request of the administrator to meet at his office at 141 S. Meridian Street, at 10 a.m., daylight saving time, Wednesday, June 3.

VA Hospital Survey. The action of the Liaison Committee with the American Legion concerning the proposed survey of Indiana veterans in veterans hospitals was called to the attention of the committee and the proposal was approved by consent, as were the proposed questions to be incorporated in the survey form.

Dr. Norman Sweet. The matter of the advertisement appearing in the May 11 issue of the Fort Wayne News Sentinel by Dr. Norman Sweet, who claims, in the AMA directory, that he is a certified specialist in internal medicine, and subsequent examination by the executive secretary with the AMA and the Medical Registration Board, was called to the attention of the committee. By consent it was agreed to have the legal counsel of the Association prepare a letter addressed to the publisher of the Fort Wayne paper calling attention to the misrepresentation made in the ad by the individual in question.

A letter asking the opinion of the Association as to whether the introduction of a cannula through the natural openings of the various nasal sinuses was or was not a surgical procedure was read. The committee instructed the secretary to reply that this was considered a surgical procedure and that the Indiana Blue Shield Plan, which is sponsored by the physicians of the state, also recognizes this as a surgical procedure and pays for this type of treatment under its master fee schedule.

A letter from Dr. James L. Doenges of Anderson, Indiana, seeking support of the Indiana State

Medical Association in behalf of H. J. Resolution 123, which is a proposed amendment to the Constitution of the United States, relative to prohibiting the United States Government from engaging in business in competition with its citizens was read, and the matter is to be referred to the Council for action.

A letter from the State Journal Advertising Bureau, requesting the donation of space in THE JOURNAL for the purpose of promoting membership in the World Medical Association, was disapproved by consent.

Remission of dues of two physicians due to illness and retirement was approved, as requested by the respective county medical societies.

Future Meetings

By consent, it was agreed that Dr. Glen Ward Lee, chairman of the Committee on Civil Defense, should attend a meeting of the Council on National Medical Emergency Service in New York City on May 31.

A letter from the Student American Medical Association was read, in which the Indiana State Medical Association was invited to have a representative attend the Student AMA national meeting in Chicago, June 15 to 17, and Dr. Howard will represent the association if he can arrange the time.

There being no further business, the committee adjourned to meet again at 6:30 p.m., July 18, at the Athenaeum in Indianapolis.

(R) Fifth and Liberty Sts., Covington
Eighth District—Hon. D. Bailey Merrill.

(R) Evansville.

(R) 119 S. Meridian St., Indianapolis

COUNCILOR DISTRICT MEETING

EIGHTH DISTRICT

Robin Anderson, M.D., head of the Department of Plastic Surgery, Cleveland Clinic, told doctors attending the annual meeting of the Eighth District Medical Society in Delaware Country club, Muncie, that while plastic surgery's primary purpose is to make the human body function more efficiently, cosmetic surgery, which is designed to improve personal appearance, also serves a useful purpose. He stressed the good psychological effect obtained by correcting both congenital physical defects and those resulting from accidents. The Cleveland surgeon spoke to the joint evening meeting of the district doctors and members of the Woman's Auxiliary.

At a business meeting held during the afternoon on the clubhouse porch, Arvin Henderson, M.D., Ridgeville, was named district president; Paul W. Sparks, M.D., Winchester, was named secretary-treasurer; and T. R. Hayes, M.D., Muncie, was elected Eighth District Councilor, to fill the unexpired term of F. R. Keeling, M.D., Portland, who

is in military service. G. B. Wilder, Anderson, is alternate counselor.

Members of the Auxiliary enjoyed dinner in Green Hills Country club, joining the doctors for Doctor Anderson's talk.

Randolph county will be host to the next annual meeting, which will also be held in Muncie.

ELEVENTH DISTRICT MEETING

The ninety-first semi-annual meeting of the Eleventh Councilor District Medical Association was held May 20 in the Public Library at Delphi with an hour's business session preceding the scientific program at 2:30 o'clock. George W. Wagoner, M.D., Delphi, was named president; W. H. Hutto, M.D., Kokomo, secretary-treasurer, and E. B. Jewell, M.D., Logansport, renamed necrologist for the district.

The 1953 fall meeting will be held in Huntington on September 16.

The scientific program, which was arranged by Charles L. Wise, M.D., Camden, was a panel discussion on "Physician and Patient Relationship", with A. C. Yoder, M.D., Goshen, C. C. Crampton, M.D., Delphi, R. A. Soloman, M.D., Indianapolis, and W. M. Browning, M.D., Indianapolis, discussing various phases of the art of practicing medicine.

A dinner meeting in the Masonic Temple concluded the meeting. Members of the Woman's Auxiliary met at 2 o'clock in the REMC Building, joining the doctors for dinner.

TWELFTH DISTRICT MEETING

Lieutenant Governor Harold W. Handley was the guest speaker at the joint meeting of Twelfth District and Fort Wayne Medical Societies in the Chamber of Commerce, Fort Wayne, on May 21. Choosing as his topic "Reselling Americanism", the speaker emphasized the need for fuller realization of the threats to many of this country's established practices and advocated conscious effort on the part of each citizen to preserve all of the liberties to which he is entitled under our constitutional form of government.

The state official was preceded by I.S.M.A. President Paul D. Crimm, M.D., Evansville, who spoke briefly on several of the current matters of general interest to the medical profession.

The afternoon program featured presentation of cases of "Cardiovascular Diseases" by Paul L. Stier, M.D., A. N. Ferguson, M.D., and R. N. Kent, M.D., all of Fort Wayne.

"Dermatological Diseases" was discussed by Drs. S. R. Mercer, H. G. Haffner, and F. G. Perry, all of Fort Wayne. They also presented specific cases.

Chester C. Guy, M.D., assistant professor of surgery, Illinois University, and staff member of Cook County Hospital, Chicago, presented a paper on "Surgery of the Duodenal Ulcer".

The business meeting with election of officers immediately preceded the dinner and evening program. One representative from each county is to be named to an advisory committee to study a resolution on advertising presented to the meeting.

Officers who will serve the district during the ensuing year are: James M. Burk, M.D., Decatur, president; R. W. Wilkins, M.D., Fort Wayne, vice-president, and Jack L. Eisaman, M.D., Bluffton, secretary-treasurer.

NINTH DISTRICT

The annual meeting of the Ninth District Medical Society, an all day affair, was held in Noblesville May 27. Golf at the Woodland course during the morning was followed by a smorgasbord luncheon in the Elks Club, Noblesville, at noon.

The three speakers on the scientific program, all specialists in the fields they discussed, were Harris B. Shumaker, Jr., M.D., Indianapolis; William M. Browning, M.D., Indianapolis, and Walter G. Reich, M.D., Chicago. Doctor Shumacker spoke on "The Role of Surgery in the Treatment of Hypertension"; Doctor Browning discussed "New Developments in the Care and Feeding of Premature Infants"; and "Diagnosis and Management of Common Gynecological Problems" was the topic of Doctor Reich's paper.

Delegates met at 4:30, selecting Lebanon as the site of the 1954 district meeting with Boone County Medical Society as host.

At the dinner served in Forest Park Inn, Dr. Paul D. Crimm, Evansville, president of Indiana State Medical Association and James A. Waggener, executive secretary, were introduced. Doctor Crimm discussed briefly a number of problems pertinent to the profession.

Guest speaker for the evening was C. Walter (Mickey) McCarty, editor of the Indianapolis News.

The Hamilton County Medical Society arranged the meeting with Dr. Haldon C. Kraft, president, presiding.

The district auxiliary met in the Elks Club at 12:30 for luncheon and had a choice of bridge or a tour of the Conner pioneer homestead during the afternoon. Both society and auxiliary members attended the dinner.

LOCAL SOCIETY REPORTS

The May meeting of **Shelby County Medical Society** was held in the Shelbyville Elks club with a business meeting at 5:30, dinner at 6:30 and the scientific program at 7:30 o'clock. Shelby county dentists were guests for the dinner and program. Dr. William Shafer, dental pathologist at I. U. School of Dentistry, was the guest speaker, illustrating his paper on "Malignant Oral Tumors" with colored film. Twenty-four members were present. The June meeting was to be a picnic for families at the summer home of Dr. Paul R. Tindall.

July 14 was the date set for the next meeting of **White County Medical Society** when 11 members met in Monticello in April. At the business meeting a delegate and alternate to the interim meeting of the House of Delegates was named and Dr. D. C. Beck, Monticello, was named chairman of the Medical Education Fund for the county.

The May meeting of the **DeKalb County Medical Society** was held in the Souders Hospital, Auburn, with 10 members present. Dr. C. A. Novy, Garrett, spoke on "Mother and Infant Lying-in Care" and led the discussion which followed. Dr. H. V. Hippensteel, Auburn, showed a film on "Self Examination of the Breast by Women" and led the discussion on that topic. The next meeting was scheduled for July 14 in Sacred Heart Hospital, Garrett. Meetings are held at 9:15 p.m.

Final preparations for the Third District Medical Society meeting at French Lick Springs Hotel were made by the **Orange County Medical Society** at their June 2 meeting in the hotel. Eight members attended. The next regular meeting of the society will be on August 4.

Dr. Fred Brown, Fort Wayne, spoke on "Common Derangements of the Shoulder

Joint" at the May 12 meeting of the **Adams County Medical Society** which was held in the home of Dr. Harold F. Zwick, secretary, in Decatur. Twelve members attended and awards were made to winners of the A.A.P.S. contest. Meetings will be resumed in September.

Thirty doctors and auxiliary members of **Johnson County Medical Society** met May 13 for dinner in the Franklin Country Club. Plans were discussed for the June meeting which was a joint program with the Indiana Academy of General Practice Road Show.

Clark County Medical Society met in the Clark County Hospital Nurses' Home on May 19, holding a business meeting in which 21 members participated.

Thirty medical doctors have been accepted for staff membership of the **Floyd County Memorial Hospital**, it was reported at the May 5 staff meeting in New Albany Country Club. Tentative opening date for the new hospital was set for July 1. A full report on the construction, and the assembling of the administrative and nursing staffs was made. In order to facilitate proper organization of each department, the following doctors have been named department heads: Department of General Practice, J. W. Baxter, Jr.; Department of Surgery, John R. Higgins; Department of Medicine, K. H. Brown; and Department of Obstetrics, Nelson Wolfe.

"Gynecology Emergencies" was discussed by Dr. W. P. Moenning, Indianapolis, before 15 members of **Gibson County Medical Society** at a dinner meeting in the Emerson Hotel, Princeton, May 11. General discussion of the guest speaker's paper followed.

Henry County Medical Society met in Henry County Hospital, New Castle, May 21, for a short business meeting and several re-

ports. The Hospital Auxiliary report was made by Mrs. Roger Hammer; Mrs. Ray T. Foster reported on the Medical Society Auxiliary and Miss Dorothy Septer, superintendent of nurses, spoke on "Present Nursing Problems". Twenty-five doctors and guests attended.

Doctors of **Jackson County Medical Society**, staff members of the county hospital and office employees, met in the Seymour Country Club May 15 as guests of the Indiana Blue Shield Plan. Thirty guests attended the dinner meeting, which was followed by an explanation of the Blue Cross-Blue Shield plans.

Sixty members of **Vigo County Medical Society** met at St. Anthony's Hospital, Terre Haute, May 12, for a general business meeting and to hear a paper on "Psychiatry" by Doctor Heller.

Dr. A. R. Savage was elected president of **Fort Wayne Medical Society** at the annual meeting of the Allen county group May 19 in the Fort Wayne Chamber of Commerce. Other officers elected include Dr. A. J. Roser, president-elect; Dr. C. H. Warfield, secretary, and Dr. E. S. Zweig, treasurer. Delegates and alternates to the state convention were also named. Harry Lehman was renamed executive secretary.

At the May 5 meeting Dr. Julian R. Kaufman discussed "Allergies Seen in General Practice" at the dinner meeting in the Chamber of Commerce.

Drs. Francis E. Stout, Gerald W. Gustafson, C. O. McCormick, Jr., Donald Bowers and Sprague H. Gardiner, all of Indianapolis, were the speakers on a recorded program presented to members of **Cass County Medical Society** in St. Joseph Hospital, Logansport, May 11. Doctors and their wives attended a dinner in the hospital before listening to the telephone seminar on "Office Gynecology". Dr. Carl P. Huber, Indianapolis, was moderator for the panel.

Dr. Merle E. Whitlock, Mishawaka, was elected president of the **St. Joseph County Medical Society** and assumed office at a May 12 meeting of members in the Northern Indiana Children's Hospital, South Bend. Dr. Frank M. Scott, South Bend, was named president-elect; Dr. L. C. Bixler, South Bend, secretary-treasurer, and Dr. Agatha M. Wilhelm, South Bend, assistant secretary-treasurer. Dr. D. D. Stiver was renamed delegate to I.S.M.A. state convention with Drs. R. E. Nelson and W. R. Orr, Mishawaka, alternates. Drs. R. H. Denham, Jr., and K. E. Selby, were elected to the Board of Trustees and Dr. L. M. Bodnar to the Board of Censors.

LaPorte County Medical Society members heard Chaplain Granger Westberg of Billings Hospital, Chicago, present a paper "Teamwork in the Healing Arts" at their May 21 meeting in Peacock Fountain Inn, Rolling Prairie. He discussed in detail the training and duties of a hospital chaplain. Members of the Ministerial Association met with the doctors. The 30 doctors present voted to discontinue meetings during June, July and August, scheduling their first fall meeting for September 17.

The **Owen-Monroe County Medical Society's** annual dinner meeting in Owen county was held May 20 in Skyland Lodge, preceded by a reception in the home of Dr. and Mrs. C. E. Stouder in Gosport.

Lucian Smith, M.D., Mayo Clinic, Rochester, Minnesota, was the guest speaker at the May 21 meeting of the **Montgomery County Medical Society**. The title of his paper was "Pain Patterns in the Upper Abdomen" which he presented to 21 members and one guest. The meeting was held in Culver Union Hospital, Crawfordsville. Dinner preceded the 8 p.m. address. The next meeting was scheduled for June 18, also in Culver Hospital.

Active approval in principle for the same reasons given under H.R. 474 above.

Social Security and Disability Insurance

H.R. 383 Ltr. #3

Byrd

Similar bills:

H.R. 2070

Letter #6

Bailey

H.R. 2150 Ltr. #6

Van Zandt

H.R. 1376

Letter #4

Bryson

Would amend Social Security Act to provide cash disability benefits for totally disabled individuals. Medical examinations would be prescribed by federal officials.

Active opposition. Would represent a major step toward the wholesale nationalization of medical care and the socialization of the practice of medicine and bring about deterioration of medical care.

To amend Social Security Act by reducing age requirement if permanent physical or mental conditions prevented regular employment. Bill does not spell out criteria to be applied in making medical determinations or method of administration.

Active opposition for reasons given for H.R. 383 above.

H.R. 2000

Letter #5

Rhodes

To amend Social Security Act to provide cash disability insurance benefits for permanently and totally disabled. Does not spell out criteria to be used in making determinations or method of administration.

Active opposition for reasons given for H.R. 383 above.

H.R. 2446

Letter #7

Angell

H.R. 2447

Letter #7

Secrest

H.R. 3105

Letter #8

Van Zandt

Creating a new Social Security system including disabled persons of any age.

Active opposition in line with established position regarding total disability insurance benefits.

Compulsory Health "Insurance" and Federal Subsidization of Private Plans

H.R. 1590

Letter #4

Miller

Would authorize for federal employees, on their request, withholding of premium payments for life, health and accident insurance.

Opposition pending further information from Council on Medical Service and Bureau of Medical Economic Research.

H.R. 1817

Letter #5

Dingell

Omnibus health bill, including national compulsory health insurance.

Active opposition.

Aid to the Handicapped

H.R. 402

Letter #3

Celler

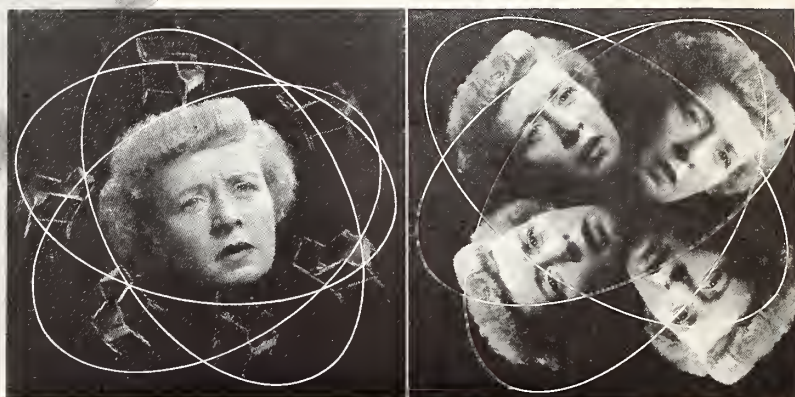
To amend various federal laws dealing with aid to blind and other seriously disabled persons and providing a comprehensive grant-in-aid program to assist states in this field.

Active opposition pending recommendations of the proposed Commission on Federal-State Relationships.

(Continued)



1. *Dizziness . . . movement is within the head.*
2. *Objective vertigo . . . the environment is in motion.*
3. *Subjective vertigo . . . the patient himself moves in space.*



2

3

TYPES OF VERTIGO:

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The disagreeable sensations of dizziness which physicians are frequently required to explain to patients have been described by Simonton¹ as varying from a slight sensation of confusion to severe vertigo.

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vertigo from sudden diplopia, visual field defects, looking down from heights and motion sickness due to hyperactive labyrinthine reaction from riding in vehicles.

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1. Simonton, K. M.: The Symptom of Dizziness, Arizona Med. 6:28 (Sept.) 1949.

H.R. 2096 Ltr. #6
 Hagen, H.R. 2147
 Ltr. #6 Tollefson
 H.R. 2149 Ltr. #6
 Van Zandt, H.R. 2300
 Ltr. #6 Rhodes
 H.R. 2342 Ltr. #6
 Wier, H.R. 2346
 Ltr. #6 Withrow
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 Chudoff, H.R. 3177
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 H.R. 3188 Ltr. #9
 Perkins, H.R. 3291
 Ltr. #9 Celler

Miscellaneous

S. 601 Ltr. #5
 Humphrey
 S. 835 Ltr. #7
 Smith
 H.R. 2769 Ltr. #7
 Wolverton

S. 967 Ltr. #8
 Taft
 H.R. 3171 Ltr. #9
 Harris

S.994
 Letter #9
 Saltonstall

S. 1514
 Letter #15
 Taft

H.R. 116
 Letter #2
 Church

H.R. 633
 Letter #4
 Teague
 H.R. 2862
 Letter #8
 Rogers

H.R. 2449
 Letter #7
 Bailey

To establish an independent Federal Agency for Handicapped.

Opposition pending report of the proposed Commission on Federal-State Relationships.

To permit factory inspections by agents of Food & Drug Administration after written advance notice.

Approval in principle provided that safeguards are included to protect the physician-pharmacist-patient relationship and confidential business and professional records.

To extend to June 30, 1960, the Hill-Burton Hospital Construction Act.

Approved.

Federal aid to local public health units.

Opposed pending the report of the proposed Commission on Federal-State Relationships.

To establish a Commission on Intergovernmental Relations to study all programs supported with federal funds and the ability of the federal government and the states to finance such programs.

Active approval of this bill and of H.R. 4406 a companion House bill to determine whether there is justification for federal aid in the many grant programs.

To prohibit interstate transportation of fireworks into states forbidding their sale.

Approved in principle because of serious injuries resulting from indiscriminate use.

To establish a Federal Board of Hospitalization with only federal officials as members.

Approved in principle but disapproves bills as written—civilians should be members of the Board and government officials should serve in advisory capacity.

To establish as an independent agency the Bureau of Clinics for treatment of chronic alcoholics and narcotic addicts.

Opposed because a program, if needed, should be under the direction of the Public Health Service.



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4.	Joseph M. Black, M.D., Seymour.....	Clifford A. Wiethoff, M.D., Seymour.....	Seymour, May 5, 1954
5.	Stuart R. Combs, M.D., Terre Haute.....	C. M. Schauwecker, M.D., Greencastle.....	Terre Haute, May 19, 1954
6.	Robert W. Kuhn, M.D., Wilkinson.....	W. R. Tindall, M.D.....	Shelbyville
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12.	James M. Burk, M.D., Decatur.....	J. L. Eisaman, M.D., Bluffton.....	
13.	John E. Luzzader, New Carlisle.....	O. E. Wilson, M.D., Elkhart.....	South Bend, November 18, 1953

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Opinions From Here and There

Prepared for your information by the Committee on Public Policy and
Legislation of the Indiana State Medical Association

CARE OF NON-SERVICE CONNECTED VA CASES CAUSES STORM in Congressional hearing on the subject. Coming about over appropriations made to the VA and requests for economy in operation of the VA care program is causing some white hot arguments to take place.

INQUIRY ON CARE DUE VETERANS IS BEGUN with the House Veterans Committee beginning hearings on the matter July 8. Representatives of Veterans Groups, the AMA, AHA and ADA and other professional groups were to be heard. Rep. Bernard Kearney (R.-N.Y.) as chairman of the Hospitals sub-committee has charge of the hearings.

STUDY WILL COVER SUCH MATTERS as feasibility of means test, reimbursement of VA by insurance companies, etc. Hearings are expected to be recessed when Congress adjourns until January of next year.

VFW SAYS AMA UNDULY UPSET—Adin M. Downer, speaking for the VFW, said, "From the alarm expressed by the AMA on this subject, one would think that the VA operated a million hospital beds, rather than a mere 114,000." He said it is inconsistent to withhold medical benefits from some veterans while making no restrictions on GI educational privileges. "Also, it might be said that if free hospital and medical care is to be extended to those who cannot pay and denied those who can pay, then it penalizes the veteran who by industry and thrift has been able to accumulate some material wealth."

DISABLED VETERAN SAYS ABUSES ARE FEW—Cicero F. Hogan said his organization has been unable to uncover any quantity of evidence pointing to abuse of outpatient dental benefits. He recommended no change in present policies covering admission into veterans hospitals of N and C cases who sign the inability-to-pay oath. DAV is against any expansion of contract hospitalization involving non-Federal facilities.

AMVETS OFFER REMEDIES with Rufus H. Wilson as spokesman, Amvets offered these suggestions: (1) Authorize Veterans Administration to investigate inability-to-pay oaths; (2) Chronic and long term cases would have prima facie eligibility for hospital admission; (3) mete out stiff punishment for willful misstatements of facts by applicants; (4) amend application form to include information as to income, net worth and number of dependents. "Non-service-connected hospitalization is by and large a most meritorious benefit," said Wilson. We repeat that abuse of this program is minor. However, it is required that every effort be made to strike at even minimum abuse. This we are attempting to do. We are certain that this committee will lend its efforts in this direction.

LEGION RAPS AMA STAND. The American Medical Association was roundly scored by American Legion spokesman for its opposition to non-service-connected medical care. Robert M. McCurdy, chairman of the Legion's National Rehabilitation Commission, charged organized medicine with "sucking the flesh and blood of veterans and then turning them over to the VA." For two decades, he told the Kearney sub-committee, AMA has been crying havoc on this issue but withholding constructive action. There is no need, he said, for change in basic entitlement to hospitalization. What might be done, according to McCurdy, is to tighten up inability-to-pay oath to extent of making it acceptable "in the absence of substantial evidence to the contrary."

AMA PRESIDENT-ELECT MARTIN will testify on behalf of the AMA and will outline the stand of the Association taken at the New York meeting of the House of Delegates. AMA's position is that hospitalization should not be offered to non-service cases, except for such long-term illnesses as tuberculosis and mental and neurological conditions where the veteran is unable to pay.

COUNCIL OF STATE CHAMBERS OF COMMERCE levels blast at Veterans program and cites growth of non-service-connected Hospital Care program. The Council points out that pressure on Congress to provide beds for more and more non-service-connected cases has resulted in a steady

increase in the number of beds from 40,213 in 1933 to 110,243 on June 30, 1952.

COMPARES RISE IN TYPE OF CARE by citing the annual reports of the VA Administration. The bulletin points out that service-connected cases had risen from 14,080 in 1933 to only 36,944 in 1952, but that the non-service-connected load rose from 19,715 in 1933 to 66,830 in 1952.

THE COST OF NON-SERVICE-CONNECTED CARE was estimated by the VA to be \$323 million in 1952 while the service-connected care cost was estimated at \$179 million for a total VA Hospital operating cost for the year of \$502 million.

ANALYSIS OF 66,830 NON-SERVICE-CONNECTED patient load as of June, 1952 shows the following: 11,830 patients had service-connected disabilities but were receiving treatment for non-service-connected disabilities; 25,736 were veterans on pension for non-service-connected disabilities; another 11,830 veterans were being treated for non-service-connected TB, psychosis and other chronic disabilities and had filed no claim that their disabilities were service-connected; 623 patients were Federal employees and humanitarian cases; 6,330 were patients who claimed their disabilities were service-connected but whose cases had not been adjudicated; and the remaining 10,481 patients were veterans who were being treated as general medical and surgical cases for less than 90 days in connection with non-service-connected disabilities and who claimed no service-connected disabilities. The above, the Council states, was taken from a survey made by the General Accounting office.

4,565 NEW BEDS ARE REQUESTED FOR 1954, continues the report, but even this is a reduction from the original request for 8,585 new beds.

COUNCIL CLAIMS LAW BEING CIRCUMVENTED by both VA Personnel and applicants alike. The Act of March 28, 1934 requires that applicants for hospitalization for non-service-connected disabilities sign a statement under oath attesting their inability to pay. The General Accounting office, the report continues, found in a study it made of VA Hospital practices that

VA personnel at times influence applicants to deny ability to pay by advising them that this is merely a formality necessary for admission. The GAO also found that applicants generally were not informed of penal provisions against making false statements in applications and even found that some VA Hospitals treated veterans despite their admission of ability to pay.

IN 26 OUT OF 46 HOSPITALS SURVEYED the report says, "It is common practice to permit an applicant to reverse his affirmative response (as to ability to pay) after he was informed that it would disqualify him for admission . . . even where there were obvious indications of ability to pay, none of the hospitals surveyed inquired whether the veteran could pay any part of his expenses."

GAO REPORT SHOWS INCOME BRACKET OF 336 cases which, from information on the application forms, indicated evidence of ability to pay. These cases included 123 with incomes of \$4,000 to \$5,000; 76 in the \$5,000 to \$6,000 bracket; 49 in \$6,000 to \$7,000 bracket; 62 in the \$7,000 to \$10,000 bracket; 26 with incomes over \$10,000 including one with a \$50,000 income. In 25 of the cases the veteran owned property and other assets valued at over \$20,000 each, and 4 of this group owned property over \$100,000 in value each. The report states, "The full extent of the abuse of the 'unable to pay' in non-service-connected cases has materially increased the cost of the VA Hospital program. Also, it has undoubtedly deprived some veterans of free hospital service who were less able to pay than those who abused the privilege."

AN OBLIGATION OF VETERANS AND THE CONGRESS says the Council that with the current population of veterans of about 20 million and growing by almost a million a year, it is time for Congress and organized Veterans groups to reconsider their positions with respect to legislation on behalf of veterans. The time is not far off when veterans and their families will comprise the majority of our people and can no longer be considered a special interest minority group. Attention of Congress and veterans groups should, therefore, be directed increasingly to assisting veterans, including their survivors, whose disabilities or death are connected to military service, and to helping other truly needy veterans instead of providing special benefits to veterans as a class.

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EARLY DIAGNOSIS OF CARCINOMA OF THE GASTRO-INTESTINAL TRACT

JOHN R. PAINE, M.D.

Buffalo, New York

LADIES and gentlemen, I appreciate very much the honor you have given me in asking me to give this Founders' Lecture of the Indiana Academy of General Practice. The challenge implied in the topic suggested by your Program Committee, "The Early Diagnosis of Cancer of the Gastro-Intestinal Tract" has been accepted. In spite of the pessimism and feeling of frustration which must be our lot from time to time as we treat patients with malignant tumors, it is well to take stock and to see with the knowledge we have at hand what the possibilities are for improving the outlook of the patient with cancer by attempting to arrive at an earlier diagnosis. I have chosen to include in the discussion this evening considerations involving only the esophagus, the stomach and the colon.

Those of us, and particularly surgeons, working in large hospitals or medical centers where patients with more serious lesions are concentrated frequently fail to realize how seldom the general practitioner comes in contact with cancers of the gastro-intestinal tract. Let us consider the following figures for a moment. Vital statistics for 1948 show that during that year 197,042 patients in the United States died of cancer of all types. Of this total number, only about 60,000 died as a result of cancer of the esophagus, the stomach or the colon. If we

John R. Paine, M.D., whose paper "Early Diagnosis of Carcinoma of the Gastro-Intestinal Tract" was delivered as the Founders' Lecture at the 1953 annual meeting of the Indiana Academy of General Practice, arrived in Buffalo where he now lives by a circuitous route. Born in Dallas, Texas



in 1906, John Paine went east to Harvard College, receiving his degree in medicine in 1931 from Harvard Medical School, Boston. Successively, he served a surgical internship at University of Minnesota Hospitals, was research assistant at University of Minnesota, assistant resident in medicine at Minnesota General Hospital and served a three year surgical fellowship at U. of M. Hospitals from 1934 to 1937. From 1934 through June, 1947, Doctor Paine rose from instructor in surgery to professor of surgery, meanwhile taking three years out for army service with the 26th General Hospital. He held rank as major and lieutenant-colonel.

From June, 1947 until the present time he has served as professor of surgery, University of Buffalo School of Medicine, and chief of the Department of Surgery, Buffalo General Hospital.

Doctor Paine's Founders' Lecture is published in *The Journal* in answer to numerous requests.

optimistically increase this figure by 20 per cent to account for patients with such lesions that

may have been cured during that year, and divide this total of 72,000 by the total number of general practitioners in the nation, which approximates about 100,000, we find that any one of them will be called upon to make a diagnosis of any one of these lesions only about once every 18 months. One of my colleagues in Buffalo, a busy general practitioner in his fifties, told me the other day that he would estimate that he did not see more than one new carcinoma of the stomach and one new carcinoma of the colon each year. As for carcinoma of the esophagus: this doctor has only had one patient with such a tumor since he began practice.

If such is the case, and with human nature such as it is, it is no wonder to me that doctors often fail to pay due attention to the early and perhaps mild symptoms for which the patient with a cancer consults him. A little discomfort beneath the sternum is much more apt to be caused by heart burn than it is to be caused by a cancer of the esophagus, but it may not be. Epigastric distress associated with some weight loss perhaps is not usually caused by a cancer of the stomach, but it may be. Unless we doctors suspect the worst until investigation proves otherwise, the correct diagnosis is often postponed until the patient has forfeited whatever chance he had for a successful complete excision of his tumor.

The importance of arriving at the diagnosis of a cancer early has been appreciated for a very long time. Celsus, the famous Roman physician who lived at the time of Christ, wrote in his "De Medicine" that "only the beginnings of a cancer permit of a cure." This statement in most instances is as true today as it was 2,000 years ago. The modern campaign to improve the results of treatment of patients with cancer began in 1912. At that time certain physicians particularly interested in the management of patients with carcinoma of the cervix believed that the results of their efforts might be improved if the public in general and women in particular could be educated to pay more attention to the early or suggestive symptoms of the lesion. As a result, the American Cancer Society was organized and a program of education was started which soon came to include all types of cancer. At first this campaign was directed toward the public in an effort to impress upon lay people

some of the cardinal early signs and symptoms of cancer and to encourage individuals in whom these symptoms appeared to consult their physicians without delay. It soon became evident, however, that we doctors as well as the general public needed education if any worthwhile progress was to be made. The physician was lacking not so much in knowledge as in a habit of thought which would consider any suggestive sign or symptom of cancer as being actually caused by a cancer rather than either not considering the possibility or more commonly hoping for the best and waiting to see—often waiting too long until the chances for cure had been forfeited.

Since 1912, commendable progress has been made in some respects. By and large nowadays patients with cancer do consult their physicians earlier, but there is little evidence yet that we doctors are doing the job we should be doing in seeing to it that our patients get the best available modern treatment without unnecessary delay. Certainly what evidence there is does not indicate that the patient with a carcinoma of the esophagus, the stomach or the colon has a definite diagnosis made any earlier in the course of his tumor than was the case 20 years ago. Why this is so is difficult to explain. It has been suggested, and I know of no better explanation, that with the increase of public knowledge patients are presenting themselves to physicians with earlier lesions, the manifestations of which are not the classical ones which the physician in years gone by was taught to associate with a malignant growth. As a result, the patient with an early lesion too often has his fears allayed for a time by the doctor who either fails to consider the possibility of a cancer or, if he thinks of it, concludes that the chances of such a lesion being present are so remote that the time and effort required to prove or disprove its presence are not worthwhile. Whatever the causes may be, somewhere along the way we must have a change if the present results in the treatment of gastro-intestinal malignancies are to be improved. If physicians would become pessimistic instead of optimistic about the chances of their patients having cancer, much more would be accomplished than by the further development and use of extensive radical surgical technic or the construction of more powerful x-ray therapy units.

During the past 12 years we have seen the establishment of 260 cancer detection clinics throughout the country which attempt to find those cancers which are asymptomatic or at least produce only minimal symptoms. The exact criteria used by these organizations in the selection and examination of their patients vary. The value of the results achieved for the money expended is open to question. I, for one, see little prospect of any such a method making any great impact on the so-called cancer problem. Other means will have to be found. Cameron,² in a recent article, has stated that a study of 52,000 patients examined in 60 cancer detection clinics showed that the incidence of all cancers found was 0.8%. The incidence in patients over the age of 60 was 3.4%.

The idea of some practical screening technic to sort out the patient with cancer is certainly intriguing, and God grant us the day when we may have an accurate practical biological test for cancer for then, and then only, will the physician be able to really make an *early* diagnosis. With our present technics the most we can do is to suspect where and when symptoms are present. All of us, I am sure, appreciate the fact that in its inception a cancer produces no symptoms whatsoever. Depending upon its location within the body, neoplasms produce symptoms only relatively early or relatively late in their growth. As far as the gastro-intestinal tract is concerned, Wangenstein¹⁶ believes that malignant tumors here, on the average, produce symptoms only after growing insidiously for about 20 months. To recognize the presence of a lesion already existing this long can scarcely be considered in the strict sense as making an early diagnosis. With our present knowledge and technics, however, this is the most that can be expected of us except in those patients in which certain conditions known to predispose the patient to cancer can be recognized. By finding and treating these precursors of cancer we can attack malignancy in a prophylactic fashion. Therefore, what we are really speaking about this evening is not the "early" diagnosis of malignancies of the gastro-intestinal tract, but "earlier" diagnosis. This is an important subject for carcinoma of the esophagus, stomach and colon accounts for 50% of the cancer mortality in men and 40% of the cancer mortality in women.

Carcinoma of the Esophagus

Carcinoma of the esophagus is a relatively rare lesion in the United States and most other parts of the world. It is important to remember, however, that men are affected five times as frequently as women and that the incidence in the southern Negro is unusually high. Despite the rather low general incidence in women, the great majority of cases involving the cervical portion of the esophagus occur in this sex.

We are only too well acquainted with the ultimate poor prognosis of the patient with esophageal carcinoma. Palmer¹³ in a recent monograph on the subject, however, states that this poor prognosis is due to diagnostic inefficiency rather than surgical ineffectiveness. Certain facts can be mentioned to support this opinion. Four-fifths of such patients have no evidence of distant metastases when first seen by a physician. At autopsy perhaps 30% of such patients present only local tumors without any lymph node involvement. About one-third of all patients in whom carcinoma of the esophagus occurs can theoretically be cured. In all likelihood these tumors have a long silent interval varying from 12 to 24 months before any symptoms are produced and in some 10% of patients the primary lesion remains asymptomatic until a moribund state is reached.

This tumor has no known precursors. Ahlbom of Stockholm¹⁶ in 1936 suggested that the Plummer-Vinson syndrome with its anemia and dysphagia frequently preceded the cervical esophageal carcinoma of women, but this relationship has not been substantiated by other observers.

The key to earlier diagnosis is the suspicion of such a lesion whenever a patient and particularly a man over 40 years of age complains of dysphagia, no matter how slight. In Palmer's opinion,¹³ it is the mildness of the symptom and not its vagueness that misleads the doctor and wastes the period when cure by excision is possible. In any case, dysphagia is the most common symptom, the most significant, and is usually the first to appear. Difficulty in swallowing will be produced only when the lumen of the esophagus is encroached upon sufficiently by either the mass of the tumor or the constriction produced by its growth to interfere with the passage of food. When only a portion of the circumference of the esophagus is involved in

the neoplastic process, dilatation of the uninvolvement usually occurs and dysphagia is postponed or if present seems to be improved for a time. Such an occurrence gives false hope to both patient and physician. It is well to remember also that solid food, when well chewed, can be swallowed with ease through a constriction of the esophagus if this has a diameter no less than five millimeters. Transient improvement in the patient's swallowing difficulties should not mislead us for intermittency of the dysphagia in the early stages is the rule. Substernal pain and regurgitation are other frequently seen symptoms but their presence in most instances indicates later stages in the growth of the tumor than dysphagia alone.

On the average, six months transpire between the beginning of the symptoms of a carcinoma of the esophagus and the making of a definite diagnosis. When one considers that the life expectancy of a patient with this type of tumor if not treated after the onset of symptoms varies according to estimates in the literature from 7 to 12 months,⁴ the importance of decreasing the six months delay now existing prior to diagnosis becomes evident. Merindino,^{10, 11} on the basis of a study of 100 cases of squamous cell carcinoma of the esophagus, believed that only one to two months of this delay period was due to the failure of the patient to seek medical advice, while four to five months of the delay was due to failure of the doctor to make the correct diagnosis. This period of delay is apparently uninfluenced by the social or economic condition of the patients. In doctors themselves who have carcinoma of the esophagus the delay period is said to be even longer than in other patients.

In making a diagnosis of this lesion there are three important elements: (1) A careful history, (2) A fluoroscopic examination of the esophagus with barium by a competent roentgenologist, and (3) An esophagoscopy examination. Merindino believes that a tentative diagnosis can be made in 85% of the cases on the basis of history alone. X-ray examination gives an unequivocal tentative diagnosis in three out of four cases and in the other one-fourth of the patients findings are suggestive. Proof of the presence of the tumor, of course, must be sought by biopsy examination of tissue obtained through the esophagoscope. The physician must not be

misled, however, by a negative examination of material obtained at the first examination. Because of the secondary inflammation and edema which attends the trauma and ulceration of the tumor as the patient continues to force ingested material past it, 10 to 20 per cent of the initial biopsies will not show the presence of tumor tissue, but rather chronically inflamed and ulcerated squamous epithelium or granulation tissue.

Carcinoma of the Stomach

Because of its much higher incidence and therefore greater importance, the question of earlier diagnosis of carcinoma of the stomach has received more attention than has been the case with similar lesions of the esophagus. None of us can view with complacency the small percentage of patients suffering with a cancer of the stomach that are cured. This probably amounts to something like 5-10%. There is, however, much evidence for the view that if some method of arriving at a diagnosis earlier could be devised, the results would be vastly improved. For instance, it is known that approximately 75% of patients with carcinoma of the stomach that are resected have involved metastatic lymph nodes and that about 85% of patients surviving resection five years or more had no evidence of involvement of any lymph nodes removed at operation. In selected series the patients surviving five or more years approximates 50% of those without lymph node involvement at the time of resection.

All of this merely points up the question: How can we detect the patient with carcinoma of the stomach before it has metastasized? Attempts to answer this question have been made in the main from three directions. These are: (1) Certain screening technics; (2) Recognition and treatment of predisposing conditions and precancerous lesions; and (3) Greater attention paid to mild suggestive symptoms.

The long silent interval before symptoms are produced in patients with carcinoma of the stomach has been variously estimated to be from 18 to 36 months. With this thought in mind, several medical centers in this country have tried to evaluate the possibility of screening large numbers of patients with fluoroscopic examinations of the stomach. The yield of such efforts, however, has been meager. Pack¹² has reported that "well" patients over 40 years of age ex-

amined in this way show one unsuspected cancer in 800 patients. Other studies have given even poorer yields. However, if selected groups of patients such as those showing no free acid in the gastric secretion or those with pernicious anemia are examined fluoroscopically, the results are more rewarding. In the examination of patients with achlorhydria, Pack¹² and Wangenstein¹⁴ have reported similar results. Pack¹² found one unsuspected cancer of the stomach in each 100 patients examined. Wangenstein,¹⁴ in a total of 832 patients over 50 years of age, found ten carcinomas of the stomach and 32 gastric polyps. Both Pack and Wangenstein have reported the incidence of silent carcinoma of the stomach in patients with pernicious anemia to be about 4%.

A further word should be said about the relationship between a lack of free acid in the gastric secretion and the presence of stomach cancer. The presence of free acid in the gastric secretion can no more assure the physician that his patient does not have a cancer than its absence can give assurance that he has. In the past too much attention has been paid to the chemical examination of the gastric secretion in attempting to rule in or out the possibility of malignancy in patients with questionable lesions of the stomach. Pack,¹² in a comprehensive study of the significance of achlorhydria found that 49% of patients with cancer of the body of the stomach and 75% of patients with cancer of the cardia of the stomach had some free acid in the gastric secretion. The percentage of patients with carcinoma of the stomach having normal values of acid concentration in their gastric secretion, however, is quite low. Other studies made by Jemerin⁸ of New York City and Guiss⁵ of Los Angeles have in general confirmed the significance of Pack's figures.

Of more practical importance are the patients with gastric polyps and those with gastric peptic ulcers. Without doubt a large proportion of both of these lesions will in time undergo malignant degeneration, although the percentage of all cancers of the stomach for which they are responsible is small, perhaps 5% in the case of gastric polyps. The incidence of polyps in patients with anacidity is increased and Wangenstein¹⁶ found 8% of such lesions thought to be benign prior to operation, malignant.

The occurrence of neoplastic changes in sup-

posedly benign gastric ulcers has been much more generally appreciated. As a matter of fact, Cooper³ believes that little progress has been made in the earlier diagnosis of gastric carcinoma during the last 20 years except that so-called benign gastric ulcers are now being operated upon more frequently and with less delay. The incidence of cancer in the benign appearing gastric ulcer is between 15% and 20%. A report from the Mayo Clinic which appeared in the *Journal of the American Medical Association* last October¹ outlines their present attitude towards the problem of therapy for these lesions. I quote: "Medical management is reserved for those ulcers that are acute, are small, appear to have the least chance of malignancy and occur in patients who have other disease that increases disproportionately the risk of surgical treatment. Medical treatment should not be prolonged beyond three weeks unless the patient becomes symptom free, occult blood disappears from the gastric contents and feces and the ulcer decreases rapidly in size." In these sentiments I heartily concur.

If our efforts to arrive at an earlier diagnosis of cancer of the stomach were confined to those patients previously described who have conditions generally recognized as increasing their susceptibility to cancer, we would be discharging our responsibility only in part. The more difficult task is to detect the patient with minimal symptoms of cancer itself. In part, this responsibility must be borne by the patient himself and he requires education. Everyone who has studied the problem has concluded that there has been little or no decrease in the period of delay from the onset of symptoms to the confirmation of the diagnosis during the past generation. Harvey⁶ has estimated this period of delay to be less than six months in one-third of patients, six months to one year in one-third, and over one year in one-third. Cooper,³ on the basis of an analysis of the New York Hospital cases from 1939 to 1951 believes that the average period of delay is about one year. Eight months of this period is estimated to be due to the patient and four months to be due to the doctor.

How can we explain the failure of the patient to consult his physician for symptoms of carcinoma of the stomach until he has put up with them for eight months? One can only guess if

he attempts to answer this question, but I would suspect that all too often the early mild symptoms are temporarily relieved in part by home or drug store remedies. At this point the patient decides to procrastinate because he is encouraged and hopes his troubles will soon be over. When his symptoms return or become more severe, he still procrastinates in many instances because:

1. He is ignorant of the dangers of delay.
2. He is unwilling to incur medical expense until forced to do so.
3. He is afraid he may have some serious condition and shrinks from learning the truth.

Inasmuch as there is no specific symptomatic pattern for the patient with gastric carcinoma, he finally seeks medical advice with a wide variety of complaints. Three frequent ones are pain, vomiting and bleeding. These, however, are not the early symptoms of cancer. For their appearance the lesion must have progressed to ulceration, obstruction and rigidity of the gastric wall.

If the diagnosis is to be made relatively early, it must first be only a suspicion or possibility in the doctor's mind, suggested by slight and nonspecific symptomatology such as epigastric discomfort, some anorexia and perhaps a slight loss of weight. Palumbo has nicely described these early symptoms as follows: "—a lack of desire for previously acceptable forms of food, discomfort after meals which cannot be called actual pain, a sense of undue fatigue at the end of the working day, perhaps a trifling weight loss or a slight degree of anemia may be the fragile clues." We are not justified in rejecting the possibility of our patient having cancer on the laws of chance or because, like himself, all too often we refuse to believe it could be true. Symptoms should not be explained on some other basis until their persistence forces both patient and physician to acknowledge that they warrant more serious consideration.

Even when this stage is reached, however, further delay often ensues. Stools may be examined for occult blood, but this test is not specific. If negative, the results can be grossly misinterpreted. The complete unreliability of the analysis of gastric secretion for free acid has already been pointed out. Fluoroscopic examination of the stomach with ingested barium

must remain as the most valuable and reliable of all the various diagnostic procedures. Gastroscopy has only a limited usefulness. As an additional means of examination in doubtful cases it occasionally finds its place. In most diagnostic centers it is rarely used.

The doctor must never forget, however, that no matter how skilled or dogmatic the roentgenologist may be, the x-ray examination of the stomach has a very definite limit of accuracy. Correct diagnostic interpretation can be achieved at the first examination in about 75% of patients. With repeated examinations this figure can be increased to about 90%. This 10% error is in large part made up of cancers in the cardiac portion of the stomach that are missed and of cancers in the body of the stomach that are interpreted as benign ulcers. After all is said and done, however, we must admire the skill of our colleagues, the roentgenologists. If we could interpret the patient's symptoms as well as they interpret the silhouette of his stomach, things would be much better.

In recent years attempts are being made to improve our diagnostic ability by studying the gastric secretion for desquamated or abraded cancer cells. At the present time this method is still in the experimental stage and the results achieved so far fall short of the results of x-ray examination. In all likelihood this new method will remain with us but, like gastroscopy, will be called upon only occasionally in the unusual situation where other evidence is equivocal.

Carcinoma of the Colon

The problem of earlier diagnosis of carcinoma of the colon would seem to offer no easier solution than is apparent for such lesions in the stomach. The silent interval prior to the beginning of symptoms is about the same. A recent study by Welch and Giddings¹⁷ indicates that approximately seven months transpires between the onset of symptoms and the patient's admission to the hospital for treatment. Despite the fact that approximately two-thirds of all patients with cancer of the colon or rectum are incurable when admitted to a hospital the proportion which are cured is considerably greater than is the case of patients with either carcinoma of the stomach or esophagus. The reason for this may, in part, be in the nature

of the tumor itself, but most likely is due to the fact that wider excision including a wider excision of the involved lymph nodes and lymphatic channels is practical.

Efforts to further improve our results by earlier diagnosis of malignancy of the colon and rectum should be concentrated along three lines: (1) excision of known precancerous lesions, (2) more frequent use of the sigmoidoscope, (3) routine performance of a rectal examination as an integral part of any physical examination.

The polyp of the colon, wherever it may be located, is without doubt frequently the precursor of cancer. One or more polyps are found in the colons of at least 2% of our population and Jackman and Mayo⁷ believe that 12% of people between 30 and 70 years of age develop polyps at some time or other. The more numerous the polyps, the more likely are carcinomatous changes to occur in one or more of them.

Three out of four of these lesions occur in the rectum or sigmoid portion of the colon where they can be felt by the finger or seen through either a proctoscope or sigmoidoscope. For an indefinite period of time such a growth develops slowly without producing any symptoms and some no doubt progress to full blown cancers before their presence could be suspected by anyone. In many, however, mild discomfort with some disturbance of bowel habits or intermittent bleeding gives a clue which the doctor should follow up with proper diagnostic procedures if he does the job his patients have a right to expect of him. In the speaker's opinion, all polyps should be removed unless such a procedure is definitely contra-indicated by other concurrent disease. Many of these will have malignant changes in some portion when examined histologically, despite how benign they may appear grossly.

Virchow in 1863 described a case of multiple polyps in the colon of a 15-year-old boy. This condition we now recognize as diffuse familial polyposis and know that with the passage of time unless their colons are removed 100% of such patients develop cancer. Cripps noted the familial tendency of this condition in 1882. Additional investigations have shown that the taint is due to a recessive gene. The disease may be passed on by either the mother or the father. Any young adult complaining of a

chronic diarrhea with mucus or blood in the stools should be suspected. If the diagnosis can be confirmed by x-ray examination, total colectomy is indicated.

The medical literature indicates that about 5% of all patients with chronic idiopathic ulcerative colitis develop cancer of the colon sooner or later. At the University of Minnesota it was found that 14% of all patients having the disease over five years developed malignancies. Dennis in a study of 263 cases found the incidence of cancer of the colon to be 6% in patients having this disease for two years or longer and 20% in patients having this disease for 20 years or longer. Cancers rarely develop prior to the development of polypoid or pseudopolypoid changes in the mucosa but the increased incidence of malignancy developing at this stage is so great that one cannot avoid the conclusion that severe chronic ulcerative colitis is a precancerous lesion. Considerable difference of opinion exists between surgeons and internists as to just what the role of surgery in the treatment of this vicious disease should be. I fail to see, however, why there should be any disagreement over the choice of treatment for a patient in which the disease has progressed to the stage of pseudopolyposis and irreversible fibrotic changes in the wall of the colon. All such colons should be removed with but few exceptions.

Need it be emphasized again that we should perform a digital examination of the rectum more regularly. I am sure that most of us are guilty of occasionally omitting this part of a physical examination. One-half of all the malignant lesions of the rectum and colon combined can be reached by the finger and two-thirds of them can be seen through the proctoscope or sigmoidoscope. There can be little excuse for our failure to promptly detect these tumors when patients consult us for any of a variety of abdominal complaints ranging from mild constipation with an occasional cramp to frank hemorrhage. As in the case of the patient who has early mild symptoms due to carcinoma of the stomach, the doctor must condition himself to suspicion such a lesion even with vague and intermittent symptoms.

It should also be emphasized that complete reliance on a single x-ray examination of the colon with barium may be misleading. Roent-

genologists miss and will continue to miss from time to time fairly large lesions in the colon. In most instances these lesions will be located in the sigmoid colon and in the vicinity of the hepatic and splenic flexures where the superposition of barium filled loops of bowel hide significant defects in the x-ray image. Two such instances have occurred in my own hospital during the past year. Suggestive persistent or recurrent symptoms warrant repeated examinations.

Some carcinomas of the cecum and ascending colon have as their first and sometimes only sign a hyperchromic anemia. The management of such an anemia must include adequate investigation of the colon to exclude the possible existence of a malignancy before definitive treatment is planned.

Conclusion

Cancer of the gastro-intestinal tract is a relatively rare disease and perhaps for this reason more than any other its presence is not recognized as early as it might be. With our present methods of treatment, earlier recognition offers the best hope for improvement in the results of therapy. This can be achieved to a great extent by continued education of the lay public to consult their family doctors for advice when certain symptoms, despite their mildness, persist and by we doctors conditioning ourselves to consistently search for cancer where the possibility of its presence is suggested or even hinted at. The real early diagnosis must await a new diagnostic technic.

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OBSTETRIC HELPS

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I SHALL endeavor not to take undue advantage of the implied comprehensiveness of my subject, but will stress briefly a goodly number of what I consider practical aids in the all important field of obstetrics. Much of what I shall have to say will not border on the scientific, and no doubt will be rated as quite commonplace. Nevertheless, I hope each of you, who serves in the field of parturition, will find at least a few pointers you will want to carry back to your practice.

I shall begin with the statement, "Every female child should be considered a potential mother." The obstetrical millennium will not come to pass until this worthy consideration is extended her; and this not only by the profession alone, but by society at large. She is to be protected to the fullest extent by all health measures, including ample intake of vitamins essential to healthy development; elimination of focal infections; and protection against those infectious diseases that reflect unfavorably during the child-bearing period.

In that *rubella* contracted during pregnancy, particularly during the first three months, is associated with a high incidence of fetal malformations, the female child, at least until a reliable vaccine is developed, should be designedly exposed to that contagion. There seems to be little grounds for the routine termination of such pregnancies as advocated by some. The United States' incident rate of the first trimester, 27 per cent, has never run as high as the corresponding rate, 90 per cent, following a severe epidemic originally reported from Australia. Personally, I question whether termination is ever justified. The diagnosis of *rubella* is sufficiently vague to be readily made in error, and such a policy, even though not routine, is sure to destroy normally formed babies. Besides, medicine in its most modern



"Let it be said, 'If we give service, only two things can prevent our success, physical death and moral death. The one is inevitable, the other is up to us'". This philosophy, expressed by Dr. C. O. McCormick, Indianapolis obstetrician, in the accompanying paper, sums up one of his major points—the overall importance of

service to the patient.

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state has never gone all out for eugenics to the extent of destroying our unborn.

The teaching of *sex hygiene* in our public schools should be replaced by the more important goal, *healthy parenthood*; the former to be emphasized only as a means to that end. Every individual has a natural desire to become a healthy parent, and we should give all possible assistance to that desire. The physiology and some pathology of human reproduction should be included in the senior high school curriculum. This would lead to an increased general interest in prenatal and parturitional care. Besides, it is all wrong to prepare a girl for life by overemphasizing preparation for a classic career at the expense of a basic understanding of that most vital function for which she was primarily created, namely, reproduction. Her physical design and certain correlated functions all but scream out the priority of that function.

Preconception examination should be routine. The increasing number of women, particularly those contemplating marriage, who come to their physician seeking such an examination, is quite convincing we are living in a better day.

* Doctor McCormick presented this paper before the Indiana Academy of General Practice at a session of the Annual Meeting, April 15, in Indianapolis.

Prenatal Care

Prenatal examination should be thorough and adequate, and should include the following,—

1. A relevant family and past personal history.
2. Examination of teeth, tonsils, heart and lungs.
3. Checking of blood pressure and urine.
4. A careful taking of the pelvic measurements.
5. Checking the Wassermann, Rh factor, and hemoglobin.

Since most patients consider pelvic measurements the most important part of a prenatal examination, for the sake of their mental satisfaction it is good policy to take these measurements at the first visit.

Outlet pelvimetry is more important than *inlet pelvimetry*. It is at the outlet where most delivery difficulties arise; most labors are arrested; over 90 per cent of forcep operations are indicated; most permanent and fatal injuries to the infant occur—especially at breech births; and the mother suffers practically all of her immediate and most of her permanent birth damages.

The least an attendant can do is to estimate the bi-ischial diameter by passing his gloved fist transversely between the tuberosities. An outlet admitting an 8 cm. fist will permit the birth of a 7 pound baby.

External inlet measurements are indirect, inaccurate, and of little value except to classify the type of pelvis, and are soon to be omitted from some leading standard textbooks. Many excellent obstetricians have ceased to use them. However, serious outlet contraction means mid-plane contraction.

The only real pelvimeter, the baby's head, can be readily applied to the inlet either manually or by test of labor, but not to the outlet until late in labor, which may be too late.

X-ray pelvimetry has come into increasing use, and although it is a valuable aid, it is not the final answer. Herewith are listed many of its shortcomings,—

1. Pelvioradiography cannot predict the *power of uterine contractions*.

2. It cannot estimate the *moldability of the cranial bones*.
3. It cannot inform us as to the *favorability or "ripeness" of the cervix*.
4. It does not differentiate against *elderly primiparity*.
5. It does not accurately disclose the *size of the baby*, particularly when conditions are not suitable for proper estimation.
6. It does not take into consideration the *dystocia of abnormal presentations*.
7. It cannot profit from the *obstetric history in multiparous cases*.
8. It cannot detect or evaluate *soft tissue dystocias*.
9. It cannot appraise the *nervous stability* of the patient, and finally
10. It disregards the *skill of the obstetrician*.

Despite its defaults, we cannot dispense with roentgen mensuration, and find it specifically indicated,—

1. When there is a history of difficult deliveries.
2. When the head is unengaged at term in a primiparous patient.
3. When the patient is an elderly primipara.
4. When there is a breech, face, transverse lie, or other abnormal presentation.
5. When the sacral promontory is readily palpated.
6. When there is any sacral deformity.
7. When the ischial spines are prominent.
8. When the pubic arch is pointedly narrow.
9. When the bi-ischial diameter of the outlet is less than 8 cm.
10. When the sum of the bi-ischial and posterior sagittal diameters of the outlet is 15 cm. or less.

When radiographic pelvimetry runs counter to clinical findings, seasoned clinical experience should not be set aside. Let us be reminded many cesarean sections result from faulty technique and erroneous interpretation.

Erythroblastosis kills more babies than does syphilis, and for that reason checking of the Rh is more important than the taking of the Wassermann.

Although one of the most important and intriguing discoveries in the last half century, the Rh factor is frequently very disturbing to many expectant parents. Those parents, where the father is Rh positive and the mother Rh negative, should be informed that the first baby is very, very rarely affected, and that no more than one Rh negative mother in 30 will have an erythroblastic baby in any pregnancy, and that in general 50 per cent of the affected babies live. However, all of these babies are not good babies.

The only treatment for the infant is blood transfusion. The best results are obtained with compatible Rh-negative female blood—not the mother's blood. All babies erythroblastic from the Rh factor should be transfused immediately after birth, preferably by the replacement method. A much lower incidence of mental retardation and brain damage follows from this technic than from the simple method. (The degree of cerebral damage does not depend upon the degree of the erythroblastic manifestation.)

Rh antibody titrations of Rh-negative expectant mothers should be routine after the seventh month.

Erythroblastosis *per se* is not an indication for cesarean section. Neither does the Rh-negative factor indicate therapeutic abortion or sterilization. If the husband is homozygous, barring legal and religious hindrances, insemination may be justified. Induction of premature labor at about the thirty-seventh or thirty-eighth week is popular in some clinics.

All females below the menopause age, adults, children, and infants, should have a serologic check on the Rh factor that they may be forewarned and protected against a transfusion with Rh-positive blood, and have their child bearing possibly foiled, and perhaps their own life jeopardized.

An Rh-negative donor list should be established at all hospitals.

Twelve per cent of all pregnancy patients are anemic. The hemoglobin, or better still, the hematocrit, should be checked at the first visit,

at six months, at term, and six weeks postpartum.

A hemoglobin of 9 mg. or hematocrit of 30 per cent warrants a blood transfusion.

A prenatal patient should be seen at least every 4 weeks up to the end of the sixth month, every two weeks during the seventh and eighth months, and every week during the last or ninth month.

The blood pressure and urine examinations should be taken and carefully recorded at each visit.

The blood pressure apparatus is the most important of all prenatal equipment. Its usefulness is not limited only to hypertension complications, but is equally valuable in handling cases of cardiac disease. Regardless of what and how many murmurs a heart may present, we are not specially disturbed so long as the pressure is maintained at 120 over 80. However, we do lend closer vigilance.

A diagnosis of nephritis or toxemia during pregnancy or the puerperium should not be made solely on the basis of albumin present in a voided specimen. This custom often extends unnecessary anxiety and needless therapy to the patient.

Likewise, the attendant upon finding sugar in the urine, should not upset the tranquility of the patient and her family by informing her she has diabetes in addition to her pregnancy, at least not until he has ruled out lactosuria or has taken repeated fasting blood sugars. We must not forget that glycosuria in the early weeks of pregnancy is usually physiologic.

In supervising the prenatal patient the possibility of toxemia and placenta previa should be kept ever in mind—particularly during the last trimester. The mortalities from these two complications can be most effectively combated, not at the time of delivery, but during the prenatal period. Indeed, they afford the greatest excuse for prenatal supervision.

As a prenatal patient sits before her physician in his office, it should occur to him, "Madam, you are a candidate for two possible catastrophes, eclampsia and placenta previa." With this in mind, he is duty bound to question her at each visit as follows, "Mrs. Jones, since your last visit, have you had any nausea or vomiting?" "Have you had any dizziness?" "Have

you had any vertex headache?" "Have you had any insomnia or sleeplessness?" "Have you had any blurred vision?" "Have you had any morning swelling of the face?" "Have you had any epigastric or upper abdominal pain?" "Have you had any spotting of blood or bleeding from the vagina?" Not until he has a negative answer to each of these questions, and has found the blood pressure and urine to be normal, has he exhausted his responsibility to the patient, nor can he say, even to himself, "Mrs. Jones, you are in no immediate danger."

May we interject: *Evening edema of the lower extremities is usually physiologic, while morning edema of the face is usually pathologic.*

A normal systolic pressure rising to 140 or 160 mm. with or without albuminuria or subjective symptoms, means *hospitalization*. A rising and sustained diastolic is equally, if not more, significant; and the younger the patient, the greater its significance.

Likewise, there should be hospitalization of all cases of painless, causeless bleeding in the last trimester. There should be no rectals, vaginals, or packing in the home. If a blood bank is not available, donors should be taken along, or better, they should be sent on ahead that they may have their blood typed and checked for the RH as promptly as possible.

The diet of the prenatal patient should not be restricted except when an abnormal weight gain is constant, or some systemic complication arises. We are all familiar with the expression, "Doctor, I eat like a horse." Particularly do we hear this during the second trimester. This sudden increased demand for food, as experienced by the majority of the patients, leads one to believe that Nature in a protective mood is trying to overcome some previous bodily deficiencies. Accordingly, I let my patients eat, knowing that the size of the baby will not be affected; that eating is one of the few pleasures of the expectant mother; and that in the majority of cases the demanding appetite will have only a temporary "run." A persistent abnormal weight gain can usually be controlled by substituting calcium-phosphorous-iron-vitamin tablets for milk. Thyroid extract and limited salt intake are often indicated and helpful. The possibility of a developing toxemia must be kept in mind.

The annoying and frequently very distressing symptom of *hyperesmesis gravidarium* is often treated too casually and inconsiderately by the attendant.

At the very certain risk of being criticized as ultra *passè*, I, from my experience of a few decades, empirically recommend so common a drug as luminal sodium, given intramuscularly in the gluteal muscle of a dosage from 2 to 5 grains. The average case requires but a single administration every 2 to 7 days. The preparation is put up in powder form in ampoules by Winthrop-Stearns, Inc. Down through the years I have run the gamut of using the various hormones and vitamins, and more recently the combination of pyrodoxine and suprarenal cortex. In our hands, especially in ambulatory cases, none have given as satisfactory results as luminal sodium. Its closest, but only fair, competitor has been oral dramimine in 25 to 50 mg. doses taken one-half hour a.c. one to three times daily as needed.

Another gratifying service to the expectant mother, especially after the sixth month, is the *maternity corset*, which in a true sense is an abdominal support. Were the husband to have an abdominal tumor of a similar size, he would quickly welcome such a garment.

A properly fitted maternity corset reduces the incidence of striae gravidarum, relieves the fatigue of the erector spinae muscles, lessens the discomfort of the softened sacro-iliac and symphysis joints, improves the body lines for dress appearance, and eliminates the need for the undesirable feature of round garters or rolling of the stockings.

In our practice we have found it most practical to have the garment fitted in our office by our experienced nurse. We also do the subsequent adjustments.

A *layette pamphlet*, given to the patient at her first visit, is an appreciated service, especially by the primiparous patient. The pamphlet, in addition to listing layette articles and naming the various stores from which they can be purchased, should include information and instructions for the mother as to her diet, clothing, exercise, personal hygiene, abnormal symptoms, schedule for routine visits, the doctor's office hours and phone numbers, and signs of beginning labor. The number of "don'ts" should be limited.

It is, also, helpful to include a separate list of articles such as nursing bottles, nipples, baby powder, hot water bottle, bath thermometer, etc.; all to be available in one package at some local drug store. The package, which may be ordered as the "Infant Package", eliminates considerable petty shopping on the part of the patient.

Another minor, but practical service, is supplying each patient with an *appointment slip or folder*, indicating the date and hour of the next appointment. This eliminates much forgetfulness on the part of the patient, keeps appointments running more smoothly, and eliminates much unnecessary phoning by the receptionist.

Being ever alert for breech presentation, transverse-lie, and multiple pregnancy, the competent attendant will practice careful abdominal palpation at every visit after the seventh month. In all cases of either of these suspected diagnoses, he will seek the aid of the X-ray. In the case of breech it will confirm the diagnosis, identify the variety of the presentation, disclose deflection attitudes, and reveal the occasional unsuspected and frequently associated pelvic contraction.

A virtual proof of breech presentation can be achieved by applying *Mengert's maneuver*. This is performed by steadying the breech with one hand while slowly, firmly, and steadily compressing the fetal head with the fingers and thumb of the other. The resulting pressure produces a marked slowing of the fetal heart rate from 140 to less than 100 beats per minute. A similar pressure to the breech produces no alteration in the fetal heart rate.

Since the fetal mortality of the breech presentation is three to five times that of the cephalic, and that of the neglected transverse-lie is 100 per cent, it is quite mandatory these two mal-presentations be corrected. With all conditions favorable, this is accomplished by external version, and is done with greater ease and more success from the thirtieth to the thirty-sixth week. The later in pregnancy the operation is performed, the greater is the need for anesthesia, preferably surgically deep ether, and the greater the number of failures.

Efficient prenatal care is as important as efficient delivery care.

All labor cases should be hospitalized. If it is important that father go to the hospital to have

his tonsils removed, and it is, then it is more important that mother go to the hospital to give birth to his offspring. By all means this applies to all previous section cases, breech, transverse-lie, and chin posterior presentations; and those cases of placenta previa, abruptio placentae, and contracted or border-line pelvis; and cases complicated by cardiac, pulmonary, and nephritic diseases.

Conduct of Labor

Analgesia in labor is here to stay, and anyone attempting the practice of obstetrics in a modern community, should first be well trained in the use of one or more of the present day methods.

A most important feature in the conduct of labor is *checking and recording the fetal heart rate at regular intervals*—every 30 minutes during the first stage; every 15 minutes during the second stage; and oftener as the moment of birth approaches.

The more closely this routine is observed, the greater the number of salvaged babies.

Let us be ever reminded that the obstetrical patient differs from the medical or surgical case in that it extends us the responsibility for two individuals, and that the stethoscope is our chief aid in checking the well-being of the one unseen.

Pelvic examinations should be made rectally. However, in the case of delayed progress in labor, or some irregular presenting part is discerned by rectal, or when determining the diagnosis of placenta previa, then, by all means, should the vaginal be utilized.

Conduct of Delivery

1. *For the sake of asepsis*, the patient should not be taken to the delivery room longer than one-half hour before the expected time of delivery. A much longer period is risky as to contamination. It is difficult to prevent perspiration, amniotic and fecal fluids from conveying in time bacteria through the draping materials—as well as the problem of keeping the drapes from becoming awry. Likewise, there is the likelihood of contamination of the instruments from prolonged exposure; and, also, the difficulty of controlling of non-sterile contacts by

the assistants, when subjected to tiresome waiting.

In such instances redraping and replacing of gowns and gloves should be a usual routine. In other words, the spirit of Semmelweis should ever prevail.

2. In general, one should follow the slogan, "*If a perineum exists, an episiotomy should be done.*" Unless apt at repairing third degree lacerations, one should go slow in adopting the routine median. It is better to guide the baby beside the rectum rather than through it.

An outstanding goal of every delivery is an intact sphincter and a nulliparous introitus. A timely episiotomy and a proper repair will guarantee both. *In repairing a perineum, one should always preserve its expression.*

3. When delivering a premature infant one should adhere closely to the dictum, "*The more premature the infant, the more generous the episiotomy.*" It is here an episiotomy is often a life-saving measure. Fully 50 per cent of all premature infant deaths are due to intracranial hemorrhage. This results from injury to the frail blood vessels born by the delicate brain-supporting structures, and is in direct proportion to the degree of moulding.

4. In repairing episiotomies and perineal lacerations, one should avoid *too many, too tight, too hard, and too haphazardly placed sutures.* When the patient's limbs are taken down from the leg-holders, all the perineal structures that have been injured fall into normal relation, and all that is necessary in their repair is to gently coapt their respective surfaces for the brief period of ten days. By that time Nature will have taken over.

5. Conditions being favorable as to skill and surroundings, the *prophylactic forceps* is an operation strongly recommended. It spares the mother the most exhausting hours of her labor, and the infant, prolonged cerebral compression.

6. In conduct of the third stage the blood loss should be checked as much as possible. *It is simpler to conserve blood than it is to transfuse it.* It is here we depend much upon the use of oxytocics. Either of the following methods is highly practical:

- (a) Five tenths to 1.0 cc of pituitrin is given hypodermically following the birth of

the baby, and one ampoule of ergotrate (gr. 1/320) hypodermically after the birth of the placenta.

- (b) The Chicago Lying-in technic. After a delay of 30 seconds following the birth of the head and the assured birth of the shoulders, 1 cc of ergotrate (gr. 1/320) is administered intravenously.

We prefer and routinely employ this latter method. In practically all instances the blood loss from the uterus is less than that from the episiotomy. We further find it eliminates the need for the administration of some ergot preparation during the first two or three postpartum days as customarily done for the prevention of subinvolution of the uterus. It thus reduces both medication to the patient and service by the nurse.

The ice-bag to the fundus has rightfully, long since become *passé*. Not only is its efficiency questionable, but it serves as an added chore to both the nurse and the patient. (Besides, 18 (??) per cent of the bags leak.)

The long standing, dogmatic dictum, "Pituitrin is a criminal agent if administered before the birth of the child," has until recently held us in abeyance in developing the fullest utilization of this oxytocic. However, as with the mastering of strychnine as a useful drug, we have developed its administration and regulated its dosage to a degree that it is now not only a safe, but a most important aid in handling such problems as postpartum hemorrhage, induction of labor, inertia uteri, and abruptio placentae.

The *intravenous drip technic* is more physiologic than the intramuscular and intranasal methods, and for that reason is safer and more efficient. Since *pitocin*, perhaps not quite as efficacious as pituitrin, reduces pituitary shock and eliminates the danger of blood pressure elevation in unrecognized preeclamptic patients, it is the better choice of the two preparations.

Technic of Intravenous Pitocin Drip for the induction of labor and treatment of inertia uteri:

- (1) Mix .5 cc pitocin thoroughly with 500 cc 5 per cent glucose solution. (50 cc of solution is equivalent to 0.5 m. of pitocin.)

- (2) For the first half hour administer with a pre-tested Murphy drip apparatus 0.25 m. of

pitocin—12 to 14 drops of the solution per minute—.8 cc of solution.

(3) After the first half hour, if .25 m. is not effective, increase to 0.5 m. of pitocin over 30 minutes—25 to 30 drops of the solution—1.7 cc of solution.

Precautions:

(1) Do not have the solution flowing when the needle is inserted—a dangerous amount of the pitocin might be given before the flow is regulated. The number of drops should be built up from zero. This risk can be completely avoided by not adding the pitocin to the glucose solution until the flow of the latter has been established and controlled. After adding the pitocin, shake the flask vigorously.

(2) The patient should never be left alone. The flow must be checked from time to time. Moreover, the clamp might slip.

An ordinary clamp, such as an irrigating can clamp, though practical, is none too safe or accurate. The special Harvard infusion clamp (Fig. 1) with its extra compression area and micrometer control is ideal, and it or a similar clamp should be available in every obstetrical department.

(3) The uterine contractions must be observed constantly. If they exceed 2 minutes or if the fetal heart tones show abnormal variation, the clamp must be shut off immediately and remain shut until the disturbances are corrected. In the meantime a normal salt solution by means of a Y-tube may be switched for the pitocin solution.

These precautions must be observed unrelentingly. A pituitary oxytocic unscrupulously administered intravenously can be 'dynamite'.

Puerperal Care of Mother

1. The greatest use of *pitocin drip* is the treatment of postpartum hemorrhage. Eastman of Johns Hopkins reports he has successfully substituted it for the intrauterine packing in treating uterine hemorrhage in 12,000 delivery cases. In dealing with this complication, the rate of flow may be increased to 60 or 70 drops per minute if indicated.

It appears pitocin drip is destined to replace

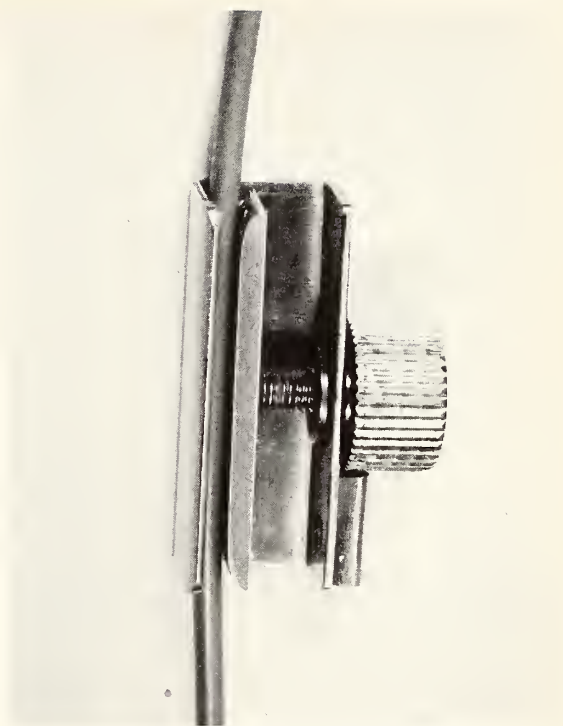


Fig. 1. Harvard Infusion Clamp.

the intramuscular use of pitocin and pituitrin, as it can be advantageously employed, in elective induction of labor, postpartum hemorrhage, in incomplete and septic abortions, some cases of hydatidiform mole, certain cases of abruptio placentae, and following the birth of the baby at cesarean section.

2. An abdominal binder for the first two or three postpartum days is gratefully accepted by the patient. This is ordered for her *comfort* only, and not as a prophylactic against hemorrhage or as an aid for figure restoration. The uterus following delivery weighs 2 pounds, and its supporting structures are extraordinarily lax, and the abdominal wall extremely flaccid. The supporting effect of the binder gives real comfort.

3. The patient is entitled to and will tolerate a *regular diet* as soon as she has recovered from her anesthetic. Her many hours of exhaustive labor should extend her the same consideration given the gridiron star, whose meal following one hour of many times less physical expenditure includes a one inch steak. Her digestive tract and forces have not been disturbed, and it would appear to be an injustice to limit her to a sloppy and soft food diet the first 24 to 48

hours after delivery, a routine frequently observed.

4. Most patients can be relieved of perineal pain by removing the vulvar pad and applying an ice-collar covered with a sterile towel. Heat from a light bulb, also, serves well.

5. The *engorgement of breasts* is readily relieved by oral stilbestrol—1 to 2 mg. taken t. i. d. for 2 or 3 days. If it is desired to dry up the breasts, the dosage is increased to 10 mg. twice daily for 4 or 5 days.

A properly applied adhesive support, *not binder*, can also be used in the treatment of engorgement. It gives complete relief, and has the advantages over the soft material supports of being completely efficient, not having to be changed at each nursing time, being comfortable, and allowing easy access to the nipples for nursing.

6. The patient can profit greatly by exercises during the puerperium, and some such routine as the following should be prescribed.

- a. First day and after: Lie on stomach $\frac{1}{2}$ hour or longer t. i. d. This replaces the awkward and embarrassing knee-chest position.
- b. Second day and after: Raise one foot then the other with the knee straight toward the ceiling 10 to 12 times night and morning. Sit on edge of the bed and dangle feet 5 to 10 minutes 2 or 3 times daily.
- c. Third day and after: With arms folded high across the chest, rise rapidly to upright sitting position and recline slowly 10 to 12 times night and morning following limb exercise, "b".

The patient should continue lying some on stomach during the day or during sleep, and the sitting-up exercise, "c", for one month after leaving the hospital.

7. As we retrospect through the years there arises an inner penance for the disservice we rendered our loyal patients who so faithfully accepted our orders to remain in bed 10, 12, 14 or more postpartum days. This late rising delayed their convalescence, and often so because

of unnecessary complications resulting therefrom.

Early rising is now commonly conceded to have the following advantages,—

- a. An increased sense of physical well-being and a better psychological attitude.
- b. A reduced incidence in such complications as cystitis, respiratory infections, thrombophlebitis, and pulmonary embolism.
- c. A more rapid involution of the uterus.
- d. An economic saving because of a briefer hospital stay, and
- e. A shorter convalescence period.

Routines of early rising vary in different clinics. Ours is as follows,—

Second day: In the morning dangle feet 2 or 3 times. In the afternoon sit in the chair once or twice 15 to 30 minutes, and to toilet.

Third day: About the room and up and down the corridor.

Fourth day: Shower bath.

Fifth day: Privilege of washing hair.

The daily exercises (6) listed above are conducted in conjunction with these early rising privileges.

Although early rising may enable a patient to leave the hospital as early as the 5th day, it is preferable that she not do so before the 8th or 10th day. She is well entitled to the extra days of hospital rest.

Care of the Infant During the Puerperium

1. The first service to the infant is thorough aspiration of its nasal and bronchial passages. This is to be done before *any* stimulation of respiration. The nares and mouth can be aspirated with a 2-ounce rubber ear syringe as soon as the head is born. Immediately following the cutting and ligating the cord, the trachea should be freed of mucous with a soft rubber catheter.

Aspiration of cesarean born babies should be routine, since it has been found their bronchial tree contains on the average 6 to 8 cc of mucous,

which is three times the average found in babies born per vaginam. No doubt this fact accounts for many of the unexplained deaths that occur shortly after birth among babies delivered by section.

All apneic babies are to be given oxygen.

2. The care of the infant in the majority of cases, at least until the pediatrician or family physician takes over, becomes the responsibility of the obstetric attendant.

We put the baby to the breast 12 hours after birth. This is done chiefly to give the mother the pleasure of seeing the baby. During the next 24 hours it is taken to the breast every 6 hours. Babies weighing 7 lbs. and over are then put on the 4 hour schedule (both breasts at each nursing), omitting the 2 a.m. feeding. The baby readily adapts itself to this schedule, and spares the mother the chore of nursing at 2 a.m. after she leaves the hospital.

Babies weighing $5\frac{1}{2}$ to 7 lbs. are placed on a 3 hour schedule during the day and 4 hour at night, nursing on but one breast at each feeding.

Premature and immature infants (less than $5\frac{1}{2}$ lbs.) are given incubator care, and are not given water, food or a bath the first 24 hours.

3. We believe a supplementary feeding until the breast milk is established is well indicated. It prevents inanition fever, reduces the so-called physiologic birth weight loss, and affords the mother considerable peace of mind.

Our favorite formula, a simple and practical one, is the following:

Evaporated milk -----	$\frac{5}{8}$ IV
Karo syrup -----	$\frac{5}{8}$ ss
Boiled water -----	$\frac{5}{8}$ VIII

Sig. $\frac{5}{8}$ 1—11—P.C. Until breast milk is established.

4. *Circumcision.* Too many babies are needlessly circumcised, and there are two common errors in the usual technic: the removal of too much foreskin, and unnecessary suturing. (Notwithstanding, 'How divinely destiny shapes our ends, though roughly we may hew them.')

Nature intended the glans be completely covered. Therefore, we strive to have it at least two-thirds or three-fourths covered. The cornification of the epithelial covering of the exposed

glans, which results from the glans rubbing against the trouser flap during the many years of growing manhood, sometimes hampers the pleasure of the marital act in later life. Also, ulceration of the meatus and its resulting stricture are reported to be predominately found among circumcised children.

Hemostasis is the only indication for sutures, and they are rarely found necessary. The clamp method greatly eliminates their need.

An excellent *circumcision dressing* is a rolled five or six inch piece of surgical gauze three-fourths of an inch wide, autoclaved in albolene. The dressing is applied by wrapping it firmly about the penis, and it is not disturbed until it is ready to drop off about the third or fourth day. At that time the wound is sufficiently healed as not to require further dressing. The two advantages of this dressing are it does not have to be changed, and it permits the infant to urinate through it rather than into it.

5. A much appreciated service, particularly by the mother and grandmother, is the *removal of the cord stump* before the baby is taken from the hospital. This can be safely done as early as the fifth postpartum day, and is readily performed by twisting the stump off either with a piece of gauze or with the aid of a hemostat. The oozing base is treated with a silver nitrate stick, and then covered with a tincture of merthiolate dressing. This has been our routine the past several years, and we can strongly recommend the procedure.

Postpartum Care

The responsibility of adequate postpartum care does not end at the six weeks examination, but should be continued throughout the first year with check-ups at three months, six months, and one year.

At the six weeks examination, the mother should be checked as to involution and position of the uterus, perineal healing, blood pressure, urine, and hemoglobin.

Two-thirds of all retroversions that did not exist prior to pregnancy can be permanently corrected by the use of the pessary.

The infant, which as a rule has been placed in the hands of the pediatrician or family physician and checked before leaving the hos-

pital, is seen only at this visit, and is checked for the condition of the naval and circumcision.

Any endocervicitis found after the third month should be completely eradicated. This can be done in practically all cases by an office electric cauterization. But few services are more appreciated by the patient, in that it not only eliminates a rather common forerunner of cancer, but the leukorrheal nuisance as well.

A woman does not have to have a leukorrheal discharge just because she has had a baby. Postpartum care is frequently synonymic with preconceptional care.

"Human Relations"

No branch of medicine lends itself so closely to human relations as does obstetrics. *The birth of a baby is the most humane event in all life.* It evokes the most joyous interest of every family member, and the worthy attendant will capitalize upon sharing the exaltation.

Let us be reminded, the obstetrician should not wear the cheerless mask of a mortician. At all times his lot is to emanate cheerfulness, and in this light, he should always be tactful enough to have a patient smiling as she leaves his office, at each prenatal visit. The word, "easy", should be frequently employed when discussing her case with her. It is well to interject occasionally such remarks as, "Mrs. Jones, your measurements are normal. I am sure you are going to have an easy delivery." Or again, "Tell Mr. Jones, your blood pressure and urine have continued normal, and that your progress has been excellent." Yes, simple statements, but how they do register!

Above all, let us not overlook the husband's interest in the case. *When a husband asks us to deliver his wife, he is paying us a special compliment.* This is true whether or not the remuneration will be immediately forthcoming.

Certainly we should have more than a casual speaking acquaintance with him. He should be invited to make at least one visit to the office during the prenatal period. At this visit we should meet him as man to man, and let him

know we expect to give his wife the best possible care, and that we would appreciate his co-operation by getting in touch with us anytime he has any question about her welfare.

Probably our biggest service to him is keeping him informed as to his wife's progress during her labor. *Here the Golden Rule is very fitting.* It is certainly inconsiderate of us, when we allow him to "sweat it out" hour after hour in the waiting room. If the labor should be prolonged, it is a kindly thing to advise him to go home for some sleep, or to return to his office, and assure him we will report to him from time to time, or at least when his wife is to be taken to the delivery room. And when we report the outcome of the delivery to him, let us be prepared not only to give his wife's condition and the sex of the baby, but also its weight.

No greater inner warmth comes to us than that expressed in a brief note from the husband, which we sometimes receive along with his check a few days after he has taken his wife and child home from the hospital, in which he states,

Dear Dr. 'So and So',—

"Mrs. Jones and I wish to remind you of our great appreciation of the excellent service you gave us. You helped us at a most important time in our lives, and we will be eternally grateful to you.

"May your good work continue for many, many years to come."

These remarks upon "Human Relations" can be interpreted and appraised as those of "Good Public Relations," a policy so sorely needed today.

In conclusion, the overall emphasis of this presentation has been upon the importance of service to the patient. Let it be said, "If we give service, only two things can prevent our success, physical death and moral death. The one is inevitable, the other is up to us."

Finally, I would like to leave the souvenir thought,—

The mortal life of a worthy obstetrician extends far beyond his tomb.

EARLY CARE OF POLIOMYELITIC PARALYSIS

CARL D. MARTZ, M.D.

Indianapolis

AT THE very time that effectual prevention of poliomyelitis seems imminent, there appears to be an unusually large number of cases in the Indiana area. Many of these represent major paralytic problems that will require extensive medical and orthopaedic care over a long period of time. Some will require custodial rehabilitation in homes or special villages for life.

Improved understanding by profession and public alike has resulted in better care but crippling residua often remain as end results despite the best of care given anywhere. Home care by doctors, nurses, and therapists has been properly encouraged in recent years and plays an important role in the care of many cases. More specialized care for the severely involved cases requires the personnel and facilities found only in the larger hospital centers. The same basic principles apply in both situations and it is our purpose to discuss here those common denominators which we have noted in the several thousands of polioparalytics which have been under our care over a period of years.

The polioparalytic patient faces six major problems which must be solved in large measure if satisfactory living function is to be achieved.

1. Loss of flexibility from muscle spasm and contracture.
2. Loss of power from paralysis and paresis.
3. Decrease of vital capacity with respiratory difficulty.
4. Deformity — from muscular contracture and imbalance.
5. Loss of skill with disorders of gait and handwork.
6. Loss of functional stamina.

The concept of muscle spasm is now well supported by both clinical observation and experimental studies. The muscles of the polioparaly-

Carl D. Martz, M.D., who directs orthopaedic rehabilitation services at Indiana University Medical Center, writes a timely paper on poliomyelitis for *The Journal's* General Practice issue. In private practice, the author is assistant professor of orthopaedic surgery at I.U. School of Medicine, of which he is a graduate, and is active as a consultant to crippled children's services throughout Indiana. "Happily married with three sturdy children", Doctor Martz says as he tells of his personal background and the continuing fight of the medical profession to prevent polio and to keep all children sturdy.

tic demonstrate a tonic contraction diffusely distributed particularly in the anti-gravity muscles. This spasm may be short in duration or it may last for many weeks and result in a fibrosis of the muscle mass with permanent contracture. Such contractures may produce deformity as growth occurs in the child. Initially the muscle in spasm is tender to touch; and attempts to contract or stretch it are very painful. The extent and degree may change from day to day, progressing to a peak at 10 to 15 days from onset and gradually subsiding to an end point at about six weeks from onset. Residual contracture from fibrosis is not infrequent and must be combatted by every possible means. The most effectual measure to relieve the pain and spasm of the muscles in this early phase of poliomyelitis consists of hot fomentations in the manner described by the late Sister Kenny. Modifications of many types have been tried but generous packs of hot, moist wool at frequent intervals during the day and often at night have proven worth all the difficulty of application. They should be started early for tonic contraction diminishes the blood supply of muscle and this initiates a process of contracture and incoordination which may prove irreversible.

Drugs have been tried abundantly in an effort to dispel the pain and spasm of early poliomyeli-

tis but have been found wanting. Some have proved dangerous. None have thus far equalled the application of moist heat. Prostigmine was used in 80 cases in 1943 with mild benefit in some cases and few untoward reactions. Curare preparations provided limited benefits but fatalities occurred in responsible hands and we feel that it is of too little benefit and of too much danger to be applied in the care of early poliomyelitis. It is also dangerous to residual polioparalytics at the time of anesthesia. Myanesin derivatives have proven remarkably futile for pain and spasm relief in our experience. Salicylates have been helpful and priscoline and quinine have been of some help in the pain of ischemia.

The restoration of flexibility through the release of painful muscle spasm is of primary importance in every case of poliomyelitis and the use of hot fomentation, muscle reeducation, and early guided activity pave the way for further functional training.

Loss of Power

The power loss problem in poliomyelitis is largely determined by the extent and severity of the initial neuronal involvement. We cannot control this to an appreciable degree. However, the coordination of the remaining power represents an opportunity for profitable work by the patient and the therapist. It is our firm conviction that modern techniques of physical and occupational therapy represent great steps forward when contrasted with methods previously used. There are new notes of simplicity, physiologic soundness, and economy of apparatus. The emphasis upon the gross movements of ordinary living function is a pleasant contrast to the more formal gymnastic efforts of previous years. The techniques of breathing, standing, weight shifting, walking, and the hip and shoulder sequences are especially effective and appealing to both patient and therapist. The benefits of such muscle training vary according to the status of the patient and to the skill of the therapist.

The timetable of power return is not yet well understood and only generalizations are possible at this time. We feel that the potential return of any given muscle is achieved within 90 days from onset. Non-functional muscles

measuring zero to poor minus (0-25% of normal) 90 days from onset rarely, if ever, increase to functional levels of power. Muscles measuring within functional limits (fair and good) at onset will almost uniformly improve during the 90 day period but the power grade changes little after this point. Endurance value as manifest by resistance and repetition loads increases slowly over a period of many months but probably reaches peak around one year from onset. The various muscles differ somewhat as to their frequency of involvement and also vary in their potential of return. Such differences have not yet been accurately calibrated and efforts at prognostic forecast are still prone to considerable error.

Decrease of Vital Capacity

This problem is not limited to the respirator cases and is not peculiar to the earliest phase of the disease. Periodic spirometric studies have revealed a limitation of vital capacity in a majority of severe polioparalytics. This tends to improve with the restoration of flexibility but often remains restricted. Efforts to improve the resilience of the chest wall and the efficiency of the breathing mechanism combine the contributions of the physical therapist, occupational therapist, speech therapist, and to a real advantage the work of the singing teacher. From the earliest phase of the disease, we endeavor to aid and encourage the acts of swallowing, deep breathing, whistling, singing, reading aloud, wind instruments, blow bottles, balloons, and similar activities. Bracing of the trunk includes spring and pneumatic ptosis pads which measurably improve the function of the impaired abdominal musculature upon sitting. Our present spirometric records will soon be supplemented by oximetric studies and both therapeutic and brace aids will be critically evaluated as to efficiency. Timing, pressure, and weaning from respiratory aids should be placed on a firmer clinical basis as experience accumulates.

Deformities in Poliomyelitis

Deformities in poliomyelitis arise as the result of muscle contracture and imbalance. Fascial structures share in this contractural tendency and many pathologic sections of intermuscular septa, iliotibial bands, and major

joint capsules have demonstrated non-specific inflammatory change. Both contracture and imbalance produce deformity that increases with body growth. Therefore, children are to be watched much more closely in this regard than adult patients. The newer approaches to the problem of flexibility have greatly reduced the occurrence of contractural deformity, for the use of hot fomentations, mild manipulations, and freedom of positioning result in a supple and flexible musculature in most instances. However, we have contractural deformities in many muscle groups and resort to surgical correction as soon as all other efforts prove unavailing. We are prone to wait longer with the deformities of muscle imbalance and continue the more conservative measures of muscle training and orthopaedic appliances for many months before resorting to definitive surgery. Such corrective surgery may be static as in capsulotomy and osteotomy or dynamic as in motor transfers and growth control. Postural stabilization is often necessary to the severe paralytic and combines surgical arthrodeses with appropriate appliances.

Loss of Motor Skills

Loss of motor skill in the use of the hands and legs together with loss of postural skill constitute the lasting handicaps of poliomyelitis. Their restoration is at once the aim of our total program and the hope of every poliomyelitis victim. Skill is lost through contracture, paralytic deformity, disuse, and despair. Its timetable of return is lifelong for continuing efforts are always rewarding. Every modality of treatment is directed toward the most effectual utilization of residual power.

Hands are quick to undergo contracture and have a poor potential for power return. Early and intensive muscle training together with dynamic braces and functional aids such as suspension slings are helpful. Surgery for contracture and imbalance is done very early and from the beginning, priority of hand function is recognized as secondary only to breathing.

Postural skills needed for sitting, crawling, standing, shifting and finally walking are not readily regained and require long hours of practice. Here the skilled therapist is of special value. Appliances of almost endless variety ranging from tailor-made wheelchairs through crutches, walking stix, spinal supports, braces

and corrective shoes are essential items in any therapeutic program for poliomyelitis. They may be of temporary aid or of permanent use in extensive paralysis.

Loss of Functional Stamina

The loss of functional stamina in poliomyelitis has always been noticeable, but it was forcibly drawn to our attention by a carefully controlled group of soldiers afflicted with the disease. Even with normal muscles in non-paralytics, endurance rarely reached normal range until 10 to 12 months from onset. Programs for bedfast, chairfast, bracefast, and more favorably functioning patients must be individually designed to provide the greatest possible number of activities of daily living. In severe paralytics this tendency for fatigability is more pronounced and must be closely watched. Trembling or fasciculation is a common symptom and lowered vital capacity may occasionally be encountered. Nitrogen balance has not been too carefully studied but our impression is that a negative balance persists in the polioparalytic for six months or more from onset. It has become our custom to prescribe a very high protein dietary (150 Gm.) and to enforce supine rest periods during the day. Physical activities such as walking, stair climbing, cycling, and all forms of athletics are restricted and supervised. Most military candidates with non-paralytic poliomyelitis are properly deferred for a year from onset. Improved and more objective tests for endurance and stamina are needed, but we feel that if it is disregarded, the coordination of remaining power will be seriously impaired and the number of muscle imbalance deformities and static decompensations will definitely increase.

Summary

The therapeutic program for poliomyelitic paralysis should plan to achieve the greatest possible flexibility of the body musculature, through the relief of muscle spasm; achieve the finest coordination of remaining power; develop the maximal vital capacity; prevent or correct contractural and imbalance deformities; offer the best training and mechanical aids to handwork and locomotion that can be devised; and finally guide and protect the poliomyelitis victim in the conservation, development, and utilization of his energies to the end that he achieves the highest possible capacity for every day living.

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THE G.P. MUST BE FULLY TRAINED AND VERSATILE

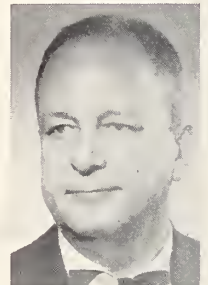
THE GENERAL PRACTICE section of the I.S.M.A. appreciates this opportunity to edit the August issue of THE JOURNAL.

The Indiana physicians in general practice are proud that there is an increased interest in this field of medicine. At the present time it has been estimated that six out of ten enter the field of general practice whereas ten years ago the percentage was one out of ten.

It is not an accident that the place of the general practitioner has survived through the years. It has been estimated that 85 per cent of the ills can be cured by the family doctor. "Worth many another man in any community" was the value that the great Sir William Osler set on the well trained physician.

The general practitioner in order to fulfill his obligation must have knowledge and excellent training. He is usually the first to see the patient and his correct diagnosis is important to the future health of the patient. It is his obli-

William R. Tindall, M.D., president of the Indiana Academy of General Practice, who virtually practices medicine around the clock, speaks with personal knowledge when he says a GP must be versatile. Doctor "Bill" Tindall, as he is known in his home town, Shelbyville, also serves as president of the hospital staff of the W. S. Major Hospital, Shelbyville, and is secretary to its board of directors. He's a DePauw graduate, got his M.D. from I.U. School of Medicine in 1932, is a fraternity and lodge man, belongs to a service club and is a trustee of his church. Doctor Tindall is a veteran of World War II.



gation to determine which case needs the attention of the specialist.

Progress is made yearly in the field of diagnosis and treatment. He must be familiar with

all new drugs introduced such as, penicillin and other antibiotics, cortisone, anti-histamines, sulpha drugs, and the use of atomic energy in diagnosis and treatment. An entirely new concept of treatment has evolved based on a better understanding of the physiological processes and blood chemistry in the body. In recent years a renewed interest has been shown in psychosomatic medicine and the effect psychological factors have in physical disturbances (a fact that the old family doctor knew right along). It is necessary for the general practitioner to be familiar with all this information.

The problem facing the physician in general practice is to take care of his patients and at the same time keep up with research and all progress made in the field of general medicine. The "road shows" which are being sponsored by the Academy of General Practice is one answer to this. Excellent programs have been arranged for the "road shows". These are held in all parts of the state. All physicians are invited to attend these discussions.

Physicians in general practice have found helpful the series of tape recordings sent out to local medical societies by the I.S.M.A., and medical schools. These recordings feature discussion in various fields of medicine by recognized

authorities. The recordings are often played at weekly hospital staff meetings. Postgraduate courses offered at the state medical schools also offer opportunity for the general practitioner to bring up to date his knowledge in any chosen field.

It falls to the lot of the general practitioner to explain to patients medical information that is published in magazines, newspapers, and heard on radio and television. Often erroneous ideas are given the public by these lay articles and an explanation of what is correct and applicable to their case is explained by the family doctor.

The physician specializing in general practice must temper scientific knowledge with an understanding of human nature. He should be alerted to community needs and work in cooperation with the specialist in raising health standards.

In order to retain the love and confidence of their patients, physicians need to rededicate their lives to service.

The responsibility to add to his knowledge and improve himself professionally will increase public confidence in a doctor's ability. The successful physician in general practice today feels an obligation to continue learning and to participate in postgraduate training.

MEDICAL CARE AND THE RURAL COMMUNITY

CUTTING across the lines of every aspect of America's problems of medical care are the needs of the nearly 60,000,000 people living in the rural areas. (Rural is used here, according to the definition of the U. S. Bureau of Census, to mean places under 2,500 population.) Most, if not all, of the problems of organization of medical services are found in their severest form in rural sections, and a large measure of the organized efforts expended in the last two or three decades has been directed specifically to meet rural needs." This statement by Milton I. Roemer, M. D., author of several books on rural medical care, points up a problem that is often overlooked in Indiana. Many of us have a tendency to think of Indiana as being a state of rather metropolitan flavor—in fact only 29 of our 92 counties are urban in their make-up. The remainder have many or all of the problems

Louis E. How, M.D., has been a member of the Rural Health Committee of I.S.M.A. for five years, working at all times to attract more doctors to small communities and to improve health generally in rural areas. He has taken his own prescription, having been in general practice in Lakeville for almost 30 years. Since 1948 he has also maintained an office in South Bend. Doctor How was alternate delegate to the American Academy of General Practice two years and is a member of the Medical Advisory Committee to the Hospital Development Association of St. Joseph County. In civic affairs, he serves as vice president of the Council of Community Services in St. Joseph County.

I wish to discuss briefly as those of special concern to those interested in improving the quality of rural medical care.

As early as 1862 some recognition was given

to the idea that rural life had its handicaps, from a health standpoint, as well as its 'natural advantages'. The report of the first Commissioner of Agriculture to President Lincoln devoted a chapter to the urgent health problems of farm families. As urban medical facilities improved and as physicians and other medical personnel flocked to the cities, the gravity of the rural health problem became increasingly aggravated.

Comparisons of the health of rural and urban people are difficult because of differences in reporting techniques and sheer lack of comparative data. However, there seems to be marked evidence that any advantage enjoyed by the country dweller in the past has been dwindling over the past 25 years. What data is available suggests that both the frequency and duration of illness is now greater in the rural areas, and the burden of physical and mental defects is appreciably higher. For those causes of death and disability which are most readily preventable or curable by modern medicine, the record of the rural population is distinctly poorer than the urban.

Regardless of the health status of rural people, it is generally recognized that they have access to and receive less medical care of virtually every type than do city dwellers. The rural areas are supplied with proportionately smaller numbers of physicians, dentists, nurses, technicians and every other class of medical personnel except, perhaps, untrained midwives, chiropractors and other drugless healers. They are served by fewer general and special hospital beds. Laboratories and even drug stores are fewer. Public clinics and health departments are relatively less adequate.

Indiana is probably much more satisfactorily supplied with many of these services than some states. There are only 17 counties in the state that do not have a hospital. There is no place in the state that is more than 20 miles from a general hospital, and very few places are more than 30 miles from a larger medical center where consultants and diagnostic aids are available.

The most immediate and dramatic deficiency in rural health services had long been the increasingly severe shortage of personnel. And, in Indiana many communities share that shortage; several of the rural counties having a ratio

of physician to population of 1 to 1,500 and in two counties the ratio is 1 to over 2,000. Since 1920 many states have taken steps to correct this deficiency and to attempt to attract doctors to the smaller community. Indiana, through its Rural Health committee of the State Medical Association has had this problem as one of the most important items on its agenda. Some of the projects undertaken by the committee include:

(1) A booklet prepared for distribution to physicians wishing to locate in Indiana.* It is available to new graduates and out of state physicians. The booklet, by maps and charts, gives all types of data in regard to communities in need of physicians; population changes in the past 10 years, types of business, schools, churches, hospitals, other physicians in the town or nearby towns and medical facilities available. There is even a suggestion or two in office planning. (2) Speakers assigned to student groups at the Medical school explain some of the pleasures and satisfactions that reward the doctor in a smaller community. (3) The committee has cooperated with other committees in attempting to bring about a preceptorship plan.

The committee has taken the leadership in forming a State Health Council with the idea of improving health facilities throughout the state.

Since the medical need most often voiced by rural communities is 'We want more doctors!' real emphasis must be placed on this area of the problem. Many communities that have tried scholarships to young men, on the promise of his return to a rural community to practice, have found the student defaulting on his contract or paying back the amount of the scholarship in order to avoid country practice. Much of this is due to the attraction of early specialization and a consequent 'specialist's career'. The attraction of the specialties to the medical student has aggravated the medical service problem. In the past decade the long term movement toward specialization in medicine has made great headway, especially since the war. In 1938, according to the American Medical Association, 20% of all physicians in private practice were specialists; in 1949, 36.5%. It has been estimated that about 80% of illnesses can be treated satisfactorily by general practitioners. In spite of this fact, the current ratio of specialists to all

physicians in private practice suggests that the general practitioner is steadily losing ground. Of course, to practice satisfactorily in rural communities a doctor should be a general practitioner—and since there are fewer general practitioners the rural communities are the ones that suffer.

Another deterrent to many young physicians settling in a rural community is the history of differences in income level between urban and rural practice. For a long time, rural incomes were much lower than urban incomes and the young physician was often attracted by this fact to the urban centers. They were also reluctant to leave behind the urban hospital where diagnostic equipment and consultants were readily available. It should be realized, however, that the differences in the physician to population ratio between the urban and rural areas overstate the true differences. The specialist's residence in the city increases the city's physician to population ratio to a greater extent than it does that of the practitioner in rural areas. On the other hand, because of improvement in communication and transportation, the rural physician can now serve a population distributed over a larger area than in the past. The trends toward hospitalization, a greater proportion of office calls, and a smaller proportion of home calls have enhanced his ability to do so. This, in turn, has led to more adequate monetary reward.

Allen Stewart, M.D., Regional Chairman on

Rural Health for the AMA, gives credit to the Academy of General Practice for what he terms 'the greatest step yet to bring the young doctor face to face with the rural situation'. This is the Preceptorship plan which permits the medical student in his senior year to live with and practice with a general practitioner for a stated term. The student makes house calls and hospital rounds with his preceptor, assists or observes in deliveries or operations, works with him in his office—in short practices medicine under supervision and becomes acquainted first hand with the work and daily activities of the general practitioner.

It is hoped that such a plan will enable the student to see and experience for himself some of the real rewards of general practice in a rural or small town setting. Here the 'patient-physician relationship', a relationship honored in the breach as much as in its practice today, can become a living reality. Here, if the physician is devoted to his profession as 'the healing art', he can probably enjoy the highest status of any member of the medical fraternity. His may well be the greatest satisfaction of any of his professional group

**Physician Placement Service of Rural Health Committee* gains wide recognition as one of the best in the nation. The Council on Medical Service of the AMA requested copies for exhibit at the New York meeting of the AMA.

INSTRUCTIONAL COURSES

THE INSTRUCTIONAL COURSES which have been given annually for more than ten years as a feature of the convention of the Indiana State Medical Association have become an important service of the Association to its members.

The success and popularity of the courses have been due in the past to excellent committee work and an active response on the part of the men who have taught them.

This year a new committee accepted the challenge of planning and presenting the courses. Again the committee members did a splendid job and we feel that we have a program which will have the greatest possible appeal as to the material presented; and will sustain the high level of excellence which has characterized the courses in past years.

The entire program with forms for making reservations is presented in THE JOURNAL this year as in the past.

G.P. SECTION MEETING—FRENCH LICK

2:00 P.M., Wednesday, October 21, 1953

VERY few of us in the practice of medicine worry about having a substantial gross income. Especially is this true where medical care insurance, both hospital and professional, covers a large segment of the population. It is, however, of great concern to us how we spend our income, invest in business interests, and prepare for future security.

At the annual Section Meeting on General Practice of the I.S.M.A. there will be presented

Allison Skaggs of the Battle Creek firm of Professional Management (Black and Skaggs) will be available for consultation at the Annual Convention of I.S.M.A. at French Lick when he will discuss **Doctors and Dollars** at the GP Section meeting.



Chairman of the Section on General Practice of the Indiana State Medical Association, Dr. Bernard E. Edwards, South Bend, formulated the original plan for the scientific articles, the editorials and the special articles in this General Practice issue of *The Journal*, with the assistance of Dr. Norman R.

Booher, vice chairman of the GP Section, and Dr. Frank H. Green, Jr., secretary.

The same group has planned the GP Section program for the 1953 ISMA convention as outlined by Doctor Edwards' editorial.

During the past two decades, while the government has had its hands in our pockets, these men have had their noses in doctors' daybooks—hundreds of them—analyzing, comparing and advising. While anyone is free to challenge their recommendations, an opinion expressed by P.M. represents the actuarial experience in handling the affairs of several thousand doctors in 13 states.

How much should I pay my office help? Should I hire another nurse and thereby increase further my overhead? Should I work more hours or less? Should I buy a farm? How much of my net income should I spend for life insurance? Where do I stand as to income—both gross and net—in comparison with others in similar situations? All these are questions that come up before these experts.

Spend the time on Wednesday afternoon, October 21, beginning at 2:00 P.M. in the Section on General Practice of the I.S.M.A. at French Lick receiving reliable information on practical business policies. Let this State meeting pay for itself by the cash value received from this down-to-earth discussion of everyday problems.

this year, a symposium—"DOCTORS AND DOLLARS."

To furnish reliable information on this awesome subject members of the Battle Creek firm, "Professional Management", otherwise recognized by all as Black and Skaggs, authors of a recent series of discussions on the "Economics of Partnerships", as presented in *Medical Economics*, will be present.



SECRETARIES ARE IMPORTANT

A GOOD doctor-patient relationship is of the utmost importance to the successful practice of medicine, whether it be in a group, in a partnership, or in private practice. Since the patient's first, and probably most frequent, contact is with the doctor's secretary or receptionist, she can either help or hinder the establishment of this relationship. How does she appear to the patient when he comes into the office? Does she greet him cordially with a feeling of warmth? Or does she greet him half-heartedly? Or not at all? If he is a regular patient, does she call him by name? Is she curt or pleasant? Does she sincerely try to be of help to the patient? Every patient enters the doctor's office with a fear—a fear of the unknown. Because patients are afraid, they are worried, and therefore, every minor irritation becomes a major one. A smile, a pleasant greeting, an assurance of help—all these can create an aura of good feeling in the patient's mind.

The practice of the secretary obtaining the initial information concerning family status, names, ages, and brief personal history is becoming more and more prevalent, and this practice is being very well received by patients. However, since this information is of a confidential nature, it should be obtained privately in a quiet manner and not in a loud, abrupt manner in a reception room full of other patients.

A calm, businesslike secretary and neat, uncluttered rooms go a long way toward creating the impression of an efficient, well-run office. Any material the secretary needs while talking to the patient should be within easy reach. Does the finding of a record take endless searching, or does it take only a few seconds? The condition of the secretary's desk also creates an impression of confusion or efficiency. Is it cluttered like the counter of an old country general store? If so, the patient has the idea that the state of the whole office is one of cluttered confusion. Or is everything in order?

A good secretary can do a great deal to further good public relations for her doctor by telling the patients who are waiting when the doctor has been held up or has been called out

Robert Neff, a member of Black and Skaggs Associates, will participate in the panel discussion at the General Practice Section meeting of the I.S.M.A. at French Lick, October 21. Topic of the panel will be "Doctors and Dollars" and here Mr. Neff discusses one facet of that subject.

on an emergency. She can give them some idea about the length of the delay, and if it is a long one, she may suggest to the patients that they may have shopping which they could do in the interim. Or she may suggest a later appointment if their illness does not require immediate attention. If possible, she should inform the patients with later appointments that the doctor is behind schedule. Waiting is difficult under the best circumstances, and the patient's time is just as important to him as the doctor's time is to the doctor.

Facial expressions are not transmitted over the telephone, and therefore, the secretary should remember that good or bad impressions are created through inflections in her voice. In answering questions over the telephone, she should endeavor to be of as much assistance as possible. In answer to the patient's query "Is the doctor in?" a "No, he isn't" leaves the caller hanging in mid air. The patient also associates the office with the doctor's workshop, and if he isn't in, he isn't working. Therefore, an answer of "The doctor is still at the hospital. May I help you?" tells the patient where the doctor is, what he is doing, and leaves the way open for the patient to state the purpose of his call. In many cases the secretary is almost as capable of helping the patient as is the doctor. Many telephone calls can be eliminated by a thorough explanation or by giving complete instructions while the patient is still in the office. Some offices make a point of asking the patient if there are any questions before he leaves.

If every employee connected with the practice of medicine remembered that there is something wrong with people who call or who pass through the front door and if she handled them on this assumption, there would be fewer public relations problems in the field of medicine.

PRECEPTORSHIPS IN INDIANA

AT THE Annual Convention of the Indiana State Medical Association in 1952 in Indianapolis a resolution was passed by the House of Delegates that, "The President of the Indiana State Medical Association appoint a committee to study the advisability of preceptorships in Indiana."

This resolution was presented for two purposes, one, to stimulate medical students to consider general practice of medicine as a career; and to assist the medical student in the understanding and the need of rural communities for adequate medical care.

In the meetings and discussions of this preceptorship committee, many pros and cons of such a plan were discussed. It was noted that 25 medical schools have some preceptorship plan in operation at this time. Most of them operate under direct medical school supervision, while others operate with assistance from various medical groups interested in such type of work. Many of the preceptorships were started in medical schools where there was inadequate clinical material for the students. Recently it has become more popular even in schools in metropolitan areas because the medical student has an opportunity to see the practical side of medicine as well as some insight into "the art of practice."

In a recent survey of the senior and junior classes of Indiana University School of Medicine the following questions were asked:

"Would you be willing to undertake a preceptorship without financial assistance of any type?" 40% answered yes. "Would you be willing to undertake such a program with board and room furnished?" 47% answered yes. Only 12.3% of those answering the questionnaire expressed no interest at all in such a program.

The Phi Rho Sigma medical fraternity has offered a voluntary preceptorship program for many years. Comments on this type of preceptorship have been favorable other than the fact that they are on a purely voluntary basis and no official credit or recognition is given by the medical school.



Serving as chairman of the Preceptorship Committee of I.S.M.A. and chairman of Postgraduate Education of the I.A.G.P., Dr. Lester D. Bibler employs experience gained through years of service to medical organizations to aid him in devising best possible ways of attracting young medical school graduates to the general practice field of medicine. Doctor Bibler has been chairman of the GP Sections of both state and national associations, chairman of Commission of Education of A.A.G.P., president of the Indiana Academy of General Practice, a director and vice-president of the American Academy.

He's an executive officer of his Legion post, member of executive council of I.U. Alumni Association, member of many fraternal and church groups, on three hospital staffs and still finds some time for his hobbies—golf, bridge, amateur movies and the General Practice of Medicine.

A preceptorship program could be established whereby medical students approved by their medical school faculty would be assigned to a practicing physician through a committee or department of the medical school in co-operation with the Indiana State Medical Association.

As designed, the preceptorship would give the medical student as a preceptee an opportunity to observe and assist in office, hospital, and home medical care of patients. The preceptor would be a member of the Indiana State Medical Association and acceptable to the committee as a preceptor. This period of four to six weeks offers a supplement in the elective work of the senior year.

A medical student who has satisfactorily completed three years of his medical course in medical school may apply for preceptorship through the office of the dean or faculty member designated for supervision of this program.

The preceptor and the preceptee would be assigned after an interview with the committee. The program recognizes the student as a young doctor observer, not as a technician to be exploited for the benefit of the preceptor. The greatest benefit would be derived from mutual

association recognizing the demands of active practice and the patient-physician relationship.

The following suggestions are offered:

That a preceptorship type of program be offered through the Indiana University School of Medicine to be available during the senior year.

That the preceptor shall be from the field of general practice.

The selection of the preceptor shall be by a committee composed of representatives of Indiana University School of Medicine, Indiana State Medical Association and Indiana Academy of General Practice.

That no financial remuneration is to be considered for the preceptee of the preceptor at this time.

The preceptee may be provided with board and room by the preceptor and no fee, charges or expenses are to be paid.

Travel expenses to and from the preceptorship are to be defrayed by the student.

That a pilot plan be instituted to work out a satisfactory program.

That the length of instruction of such preceptorship shall be not less than four weeks.

The student as well as the preceptor be screened.

That the preceptor shall be an individual

doctor rather than a group or clinic at this time.

The size and locality of the community should not be restricted.

The Commission on Education of the American Academy of General Practice has stated "that it believes the preceptor system, under which students are assigned to selected and approved practitioners for a specified period of time during which the student would live and work with a physician in normal type of daily practice, is one of the most effective methods of instruction. It is important that the general practitioners selected as preceptors are willing and in a position to devote time (without compensation) to supervise the students properly. There must be safeguards against exploitation of the students through an excessive amount of laboratory work or clerical activities. The preceptor must be careful not to ask the student to assume responsibilities for patients beyond the student's qualifications."

Such a program could be arranged and sponsored through the Indiana University School of Medicine and credit given as part of the 1,500 hours of elective work during the senior year. This program should not be attempted on too large a scale at this time. If a pilot plan could be set up in the near future it would provide the information and experience as to whether such a program would be successful.

Letter to the Editor

The Editor
Indiana State Medical Journal
Indianapolis

June 21, 1953

Sir:

In the May Journal, T. B. Noble focuses the spotlight of logic upon "closed staffs". A closed staff can—often does—perform reasonably and fairly. Again not.

So do other potential dictatorships. Unfortunately the very nature of the closed staff tempts individual members to fashion an hier-

archy, and achieve a personal desire by employing kangaroo court methods.

If comes the day that individuals no longer be biased or selfish,—then fine!

Might not it prove constructive to plug this loophole, before Political Medicine plugs our Achillean heel?

"There are oft stratagems which errors seem,
Nor is it Homer nods, but we that dream."

Robert V. Hoffman, M.D.,
1530 East Jefferson Boulevard
South Bend, Indiana.

Medical Panorama by the ASSOCIATE EDITOR

WHY ATTEND MEDICAL MEETINGS?

It is shameful that we so often must urge physicians to attend medical meetings, or that we are at times called upon to supply "reasons" for such attendance. One of the most compelling reasons is to be discovered only by actual experience at such meetings, as is well brought out in an article in the *Ingham County Medical Society Bulletin*, May, 1953, excerpts from which appear below:

If you have been careless in your weariness and have indulged yourself in the newspaper habit and have thereby grown cynical by reading too much of the antics of politicians, or if you have kept your hand too much to the plow and feel you have been left sitting high and dry—or if you feel just plain weary and don't give a damn—go to a medical convention.

If you like surgery, go to the American College of Surgeons, if you like Internal Medicine, go to the American College of Physicians, or if you have been a wise man, a True Physician, and belong to that society of the elect, The General Practitioner, go to the American Academy of General Practice. If you are a limited specialist, then go to the National or Regional Meeting of your own group. It matters only that you go. And when you get there, attend the meetings, get a good seat right down front, and learn once more why you selected the greatest vocation in the world.

If you are not already dead and full of formaldehyde, you will again walk with your head in the air and will have that look in your eye that tells the world you know where you are going.

* * *

Osler loved to say that in Medicine, young or comparatively young men have made every advance of the first rank. It was his belief that the young men should be encouraged and afforded every chance to show what is in them.

Nothing today is more evident in American Scientific Medicine than the part played by the young men in the

amazing advances being made. This is brought home with great force at any one of our great National Medical Meetings when original work and contributions of great worth and merit occupy the bulk of the program.

* * *

One cannot help but feel that surely this land has been singularly blessed. American Medicine, at the source, where every young medic makes his beginning, is in good hands. There he will see much of that vital element, which gives to Medicine the glory and the renown of achievement honorably won and strongly perpetuated, by the men and women who work in this field, and resulting in that peculiar influence which ever inspires the young generation to transcend the achievements of its teacher.

* * *

And if by some sad chance you have listened to those who would include your profession in those who work only for money, you will come away fully satisfied that the profession of medicine is distinguished from all others by what Osler liked to call its "singular beneficence."

Search the record of human achievement and where will you find anything to equal the beneficence of antibiotics, the discovery of insulin, or the eradication of malaria from large areas of the world, to mention only a few.

Your intellectual and emotional sanity and integrity, from which wisdom, kindness and courtesy are derived, will once more be firmly in your possession. You will experience a rare blending of learning and humanity which is so necessary for the man who chooses the calling of Medicine. Think about it and make your plans now.

And then there was one of our elder confreres, who used to say that while he always learned something useful at every medical meeting, nevertheless he would go regardless of that because he enjoyed "just being with doctors" so much.

President's Page

August, 1953

FELLOW MEMBERS OF I.S.M.A.:

THE NATIONAL HEALTH COUNCIL was reorganized in 1948 for the purpose of coordinating the functions of its member agencies. It desires to relate the elements in the programs of member agencies that are of common concern, through more inter-agency staff meetings, through conferences called to consider special problems or opportunities, and through inter-agency memoranda, bulletins, and news letters. In addition, the Council promises to see that the work of its members proceeds in harmony with the activities of such groups as the Inter-Association Committee on Health, Commission on Chronic Illness, National Social Welfare Assembly, Commission on Financing Hospital Care, and, here is the pay-off, Gentlemen, the Commission on the Health Needs of the Nation.

Ninety agencies have been contributing \$99,830 for coordination, and, to mention a few, this year the National Tuberculosis Association gave \$20,000, the National Foundation for Infantile Paralysis \$20,000, the American Red Cross \$20,000, the American Cancer Society \$20,000, and the American Medical Association \$4,000.

The expenditure of gift and dues monies to maintain such an overlord organization is a travesty upon the intelligence and hard earned income of all contributors of these groups. Since the objectives of the National Health Council represent a duplication of services and an expenditure of money where it is least needed, coordinating programs like this should be discontinued in favor of programs at the "grass roots level", which more likely will lend themselves to active participation by the medical and allied professions instead of social planners.

In view of this, the Rural Health Committee of the Indiana State Medical Association is responsible for the formation of the Indiana Foundation for Community Health. Its member organizations consist of the allied professions, viz: physicians, dentists, nurses, hospitals, pharmacists, and veterinarians. This group will direct a community health program throughout the great State of Indiana. They will organize Community Health Councils to which will belong all organizations which are interested in the health and welfare of their respective communities. These local groups will depend upon the Indiana Foundation for Community Health for information, aid, and guidance. Through this set-up health needs can be diagnosed and the proper therapy instituted. Work of this nature now carried on by sedulous groups can be simplified, coordinated, and economized. It will reduce the number of committees organized for the average citizen's eucrasia. As physicians, we should welcome

and support it. As individual members of civic and lay-health groups, physicians, dentists, nurses, pharmacists, veterinarians can be pressured or coerced into projects which are often questionable in character and ultimate motif. However, we can feel free to support projects which the Indiana Foundation for Community Health supports since they will have the sanction of the allied professions before their presentation.

In supporting this local level program, you will be happy to know that the American Cancer Society and the American Medical Association have withdrawn their allotment to the support of the National Health Council, beginning January 1, 1954. Vocal condemnation of N.H.C. through your local Tuberculosis Association, the National Infantile Paralysis Foundation, and the American Red Cross will help bring about their future withdrawal. If they don't withdraw, don't give. If more organizations were made to pinch their pennies, they would be more careful about such visionary and usurious spending. The future demands wise economy on the part of all medical and lay health organizations.

One should beware of organizations which wish to stress their national and ecumenical character, in deference to their state and local obligations. This apprehension should not apply to groups like the World Medical Association which is fundamentally a world-wide organization with a world-wide objective. This organization is a far different cry from the World Health Organization, a component unit of the U.N., perhaps a distant relative of I.L.O., or at least they show cousinly familiarities. Although I am a member of W.M.A., I voted against endorsement of W.M.A. by the I.S.M.A. for the reason that the I.S.M.A., as such, has no voting control over the policies of W.M.A. To endorse a principle or project of another organization at times may be politic, but to give a blanket endorsement to one over which you have no voting power is analogous to "taxation without representation". Therefore, to endorse the Indiana Community Health Foundation which has been conceived and delivered into the homey atmosphere of the allied professions by our own Rural Health Committee presents us with an infant which we hope will reach maturity under the tutelage of I.S.M.A. To endorse kindred organizations, like W.M.A., F.A.C.S., A.A.P.S., F.A.C.P., A.C.G.P., or lay health groups like N.T.A., N.H.C., or A.R.C., A.E.S., A.H.A. is a "horse of another color", which might at any time involve your local society, the I.S.M.A., and the A.M.A. in a web of political headaches and entanglements. These kindred groups prosper because of their own objectives and merit, and not because of reciprocal endorsement by the I.S.M.A. or the A.M.A.

Paul D. Grimm M.D.

P. S. "It's difference of opinion that makes horse races."

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

FRONT DOOR OR BACK DOOR

One doesn't hear as much talk about socialized medicine now as when Mr. Oscar Ewing was promoting the scheme under Mr. Truman. But the danger is still there.

The danger is there because the nation's medical schools are running in the red each year. There are fewer doctors than we need in the armed services and in civilian life because the schools cannot produce enough and keep their doors open.

This problem was recognized by Mr. Eisenhower when he was president of Columbia University. He organized a board, chosen from across the nation, to form the National Fund for Medical Education.

The people he asked to serve have learned a lot, now, about the problems of the nation's medical schools. They estimate the annual deficits of the country's 79 accredited medical schools at \$10 million. And costs are mounting every year.

The problems of the schools, as these people see them, are many, but their choices are few. They can lower their teaching standards, or reduce the number of doctors they graduate, or rely upon the Government for support.

The dangers in the last source are as obvious as they are real. If the nation's medical schools ever are forced to rely upon Government support for their existence, Government control would inevitably follow. And control of the medical schools would lead as inevitably to control of the entire profession. So there again we are faced with the same threat of socialized medicine.

Recognizing this danger, the national fund has been helping out the schools. The nation's doctors have contributed 50% of the total aid, and national foundations and industry have helped out.

The choice wasn't hard for these people to make, for in the end it was only a choice between free schools and controlled schools. And even though there is less talk about socialized medicine now than a few years ago, the danger is still there. For it can come in the back door as well as in the front door. And medical schools in need of funds provide an easy entrance.

—*Wall Street Journal*

HEADS IN THE SAND

In rejecting President Eisenhower's \$28,000,000 cut in veterans' hospital funds from the \$585,000,-

000 budgeted by Truman, the House Appropriations Subcommittee is continuing to act emotionally in a dilemma requiring the most sober kind of calculation.

The nation owes the veteran the finest and most unstinting lifetime care money can buy for his service-connected disabilities. But there are now almost 20,000,000 Americans, mostly under age 50, who will be entitled to receive care for non-service ailments simply on their own statement that they are unable to pay. And right now 64 per cent of veterans' hospital beds are occupied by patients suffering from non-service-connected conditions.

We are rapidly becoming a nation of veterans—both men and women—and the clear indication is that before we get out of the current hostilities, in which 3,700,000 men and women have already served, the trend will be completed. The name for Federal medical service for the bulk of the population is "socialized medicine." In election after election the American people have decisively rebuffed proponents of socialized medicine. But if the issue is adroitly intertwined with the welfare of our fighting men even the most patriotic of our congressional leaders seem unable to detect the danger.

The danger is very real at this stage. The Veterans' Administration now employs 7,000 doctors and has an equal number on call. This creates an artificial shortage of physicians for the civilian population, arousing complaints about inadequate medical practice. And the shortage is not being relieved materially because more and more graduates of medical schools are going directly into the armed forces. While many small communities cannot get a doctor at all, and some doctors must serve more than 700 possible patients, the Army uses one doctor to each 275 men, the Navy one to 195 in service and the Air Force, one to 315. And these men and women, Lord be praised, are the healthiest of the population.

Both before service and after service, our doctors and veterans are steadily acclimated to bureaucratized medicine—or "socialized medicine"—almost without being aware of what is happening.

Representative Teague of Texas, a member of the House Veterans Committee, stated the issue squarely when he accepted the obligation of Congress to "staff the beds, but tighten requirements

on who goes into them." He wants proof of inability to pay on the part of veterans seeking hospitalization for non-service-connected ailments.

If just this were done, we could all have confidence that sums appropriated for the V.A. would be justified completely by the nation's indebtedness to the veterans.

And if it is not done, we are failing the veteran himself by keeping our heads in the sands of

emotionalism while our larger responsibilities to him are forgotten. And these include the erecting of such safeguards against extravagance and bureaucratic drains on the economy that would wreck the value of future payments to war widows, orphans and the wounded. Defending the America for which the veteran risked his life is part of our obligation to him.

—*Indianapolis Star*

PUBLIC RELATIONS FOR THE GENERAL PRACTITIONER

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Chicago

I GREATLY appreciate the privilege and opportunity of addressing your Fifth Annual Scientific Assembly. It is encouraging to me that you have seen fit to incorporate a discussion on public relations into your scientific program, because we feel it is an extremely important subject at this time.

In discussing the public relations of the general practitioner, I hope I can get across to you that in public relations it doesn't make any difference whether a physician is a general practitioner or a specialist. Both are physicians, and as such, our public relations program should be directed at all physicians—not at specific segments within the medical profession. I think we are all working toward the same goal fundamentally and it doesn't make any difference whether we are surgeons, ophthalmologists or family physicians.

Medical public relations is as old as time itself. The difficulties experienced by Hippocrates, Galen, Semmelweis, Pasteur and Koch in selling medical science to the public makes our PR problems today somewhat insignificant. Down through the centuries physicians have practiced public relations. We can appreciate the PR techniques a doctor used in collecting his fees a century ago: he entered the home of his patient with his high top hat and his gold-headed cane, making no charge whatsoever; but he left his hat on the stand in the front hallway and expected his fee to be in it when he



As director of the Department of Public Relations and assistant to the general manager of the American Medical Association, Leo E. Brown has constant opportunity to observe and evaluate public relations policies in the medical profession. In his paper presented before the annual meeting of the Indiana Academy of General

Practice he presents some of the problems within the profession, offers preventive measures and when necessary, the prescription to alleviate an unhealthy condition.

was ready to leave. Of course, medical practice has changed and changed for the better. Today we realize the need and importance of better relationships between the family physician and his patients.

Although the public relations of the American Medical Association began when the organization was founded 106 years ago, it was not until 1945, when socialism began to cast its shadow over medicine, that the profession began to give serious thought to the need for action in the public relations field. It was not until 1949, when the juggernaut of socialized medicine was rolling with the political might of a national administration behind it, that the profession realized something really should be done. In 1949 the National Education Cam-

paign was developed with one specific objective—to educate the American people regarding the dangers of compulsory health insurance.

Since that time the emphasis of our public relations program has become increasingly positive in nature. We have tried to find out the answer to this question: why were people willing to support a government plan to provide medical care? We have tried to analyze what made people feel the government could do a better job in delivering medical care than private medicine is doing.

We have made an effort to devise a program to correct some of the shortcomings that existed in medicine in order to obtain the confidence of the American people.

The public relations of an individual or an organization is influenced by everything we do and everything we say. Medicine's public relations will improve only in direct proportion to the improvement in the public relations of the individual physician. Respective medical organizations will share in this profit. In other words, our association must understand the public and the public must understand our association.

Public relations, I would say, is based upon effective service plus an interpretation of the services that we have to offer. We must admit the fact that we have public relations whether we want it or not. Here's the important question: do we have good public relations or bad public relations? A public relations program does not become necessary simply because we are doing things wrong, but many times because the things we are doing right are either unknown or misinterpreted.

Public relations has become widely accepted throughout the medical profession in the last eight years. Here is a good example. In 1945 there were some 40 paid executives in medicine. Today there are more than 140 executive secretaries and public relations personnel assisting the medical profession in the promotion of their public relations program. As a matter of fact, 44 of our states now have executive secretaries and public relations personnel. Their budgets range anywhere from a few thousand dollars to some \$80,000 in the various states.

Your own state of Indiana has been one of the leaders in this entire program of improving the public relations of physicians. You are to be congratulated for the support you have given

this particular program, and I trust that under the able direction of Jim Waggener and your state and county medical societies that you will see the need to support all the activities of the county and state societies. I would particularly appeal for aid to their public relations programs.

You know, good public relations is something like making love—you have to be willing to participate in it if you expect to get much satisfaction out of it. It is not a disguise for our shortcomings—it is not a propaganda campaign that is going to cover up things that are wrong—and it is not just newspaper publicity. In my opinion, good medical public relations is prompt, courteous, efficient service made available 24 hours a day and 365 days a year.

Yes, it is a big order, but the general public has come to expect much of the medical profession. I would say that the medical public relations throughout America is made up primarily of the public relations of each and every individual physician. If you do things wrong that affect relations with you and your patients, the effects will show in bad PR for the entire medical profession.

It is vitally important that you, as a general practitioner, practice sound public relations every day you practice medicine, both at work and at play. Because you are a physician, you are looked upon as a leader in your community. By and large, I think you are greatly respected. Consequently, everything you do and say will affect your public relations.

I would say that one of medicine's greatest weaknesses at the present time is within the profession itself. We have a golden opportunity to do many of the things that were left undone when it became necessary for us to fight for the freedom of medicine. Even though the old Wagner-Murray-Dingle bill, the Flanders-Ives bill, and a number of other socialistic pieces of legislation have been thrown into the congressional hopper, medicine is no longer under the ax of compulsory health insurance. Socialized medicine is no longer a major threat.

Are we taking advantage of this golden opportunity? It seems that internal strife has developed and dissatisfaction has arisen within the ranks of medicine. Unfounded accusations have been hurled in the public press. Medicine's dirty linen has been washed in print when it should have been laundered within the pro-

fession. As a result, public confidence in the family physician has been undermined.

On the political scene the honest efforts of the leaders of medicine have been heralded as selling the profession down the river. Past-presidents of the association have been reputed to have accused the association of making a deal with the American Legion for their support of voluntary health insurance in return for a hands-off policy on non-service connected disabilities so far as veterans are concerned. A squabble is being aired in a state legislature over a drug that has doubtful value. It would appear that we are our own worst enemy. Physicians themselves have prompted much of the unfavorable publicity that has developed throughout the country recently. It would seem that a concerted effort is being made to divide and conquer the profession when now, above all other times, we have a golden opportunity to progress.

Medicine is as democratic in its organizational structure as the United States itself. Recently, I was shocked to read that only 12 general practitioners were listed as members of the House of Delegates of the American Medical Association. With approximately 100,000 general practitioners in this country—two thirds of the nation's practicing physicians—it would seem that the general practitioner should dominate the House of Delegates. I don't know the reason for the current situation, but I strongly recommend that you give all the support you can to your local county and state medical societies. Take an active part in their activities. If you show more interest in their activities, I am confident that the general practitioner will be more equitably represented in the policy-making bodies of organized medicine. This is necessary if we are to have a truly representative organization.

It seems to me that what we need in medicine today is more faith in our leaders and in those with whom we work. We need less professional jealousy and above all, we need more interest in the public and less in ourselves. We need to unite to do some of the constructive things that have been left undone.

When we were under attack, we joined together in a united front to combat the particular issue. Now, when we have an opportunity to make really huge strides toward improving the

practice of medicine, we squabble among ourselves.

We are never going to be able to develop a sound public relations program for medicine unless we can present a united front before the general public. That does not mean we cannot have honest differences of opinion. Our organization, like America, was founded upon the premise that honest conviction should be voiced in every area.

Since the Academy of General Practice was organized, it has had the finest relationship with the American Medical Association and has cooperated at every turn. I have had the opportunity of speaking to a number of state academies and it has been a most gratifying experience on every occasion. Many of our men have attended your various annual meetings. I think the support you have given American medicine has been significant because you have looked up to the American Medical Association as the fundamental organization of medicine of which you are an integral part.

One of the major problems facing medicine today appears to be the complaints about the cost of medical care. People resent paying their medical bills. Why? Because they must pay for something they neither wanted nor asked for in the first place, and for which they have very little to show after payment. A natural resentment is built up within the individual.

I recall that not too long ago I bought a new television set. It cost me \$500 and I agreed to pay \$100 down and \$60 a month for a certain period of time. I did not resent making my monthly payments because I was getting continual enjoyment out of the set. But it is altogether different with medical costs and I think we should keep this in mind when the public criticizes medical care costs. Unfortunately, the individual physician is unjustly blamed for the total cost of medical care, which as you know involves hospitalization and drug costs as well as the cost of a physician's services.

A few days ago we answered a letter which appeared in the Chicago Daily News written by Editor John Knight, in which he complained that the cost of medical care was much too high. We attempted to point out to him that while medical costs had increased 60% the cost of living had increased 90%. However, it was

significant to note that between 1950 and 1953 the cost of medical care had increased 17% as compared to a rise of 18% in the cost of all goods and services. Thus in the past three years medical costs have kept pace with the cost of all goods and services.

We feel that one of the major criticisms of medicine—the cost of medical care—is due primarily to the reluctance of the physician to explain the costs of his services to the American people. We would like to encourage all physicians to discuss frankly with their patients their fees and services, because we have learned that the majority of complaints which come to our mediation committees today revolve around fee misunderstandings. Therefore, it is our responsibility to explain the cost of medical care to each of our patients and to provide patients with an itemized account of the services rendered.

I would like to tell you of an incident that happened in Texas. A physician was called at 2 a.m. to treat an emergency case. Though the woman was not his patient, he got up out of bed and treated her immediately. The next day was Labor Day, but nevertheless, the physician came down to his office at 9 o'clock and gave the woman a number of tests, some of which were indicated and several which she requested. She was then hospitalized for three days. The total charge was \$90. Upon receipt of the bill, her husband was very angry about the cost and proceeded to give the physician a tongue-lashing about the high cost of medical care. It was then that the physician said, "I'm sorry that we did not have an opportunity to discuss my fees because you brought your wife in as an emergency case. I felt you wanted me to give her the same type of treatment that I would have given my own wife under the same circumstances, but inasmuch as you are dissatisfied, there will be no charge whatsoever for professional services. I am going to ask, however, that you do pay the cost of the hospitalization and of the various tests."

The man, still as mad as ever, said he was not asking for charity and wrote out a check for the entire amount. The following day the physician wrote him a nice letter, returning the check, and explaining that because of the man's dissatisfaction, he was not going to accept payment. The man then wrote a check for the

cost of the hospital care and tests. Since that time, he has brought more patients to that particular physician than he could possibly care for, because he realized that the doctor was treating him fairly. A frank discussion of fees and services between the physician and patient will eliminate a great many of the misunderstandings that have developed insofar as our public relations program is concerned.

Not too long ago, a woman came into my office complaining about the cost of an operation which had been performed in Palm Beach. The surgeon had charged her \$300 for the operation which she willingly paid because she was well-satisfied with his services. She also had paid the anesthetist \$50 without complaint because she realized his services had provided her with a greater amount of protection. What she did object to was the assistant surgeon's bill which at no time had been explained to her. She had not known there would be such an expenditure and had never even seen the assistant surgeon. Her objection went back to a local mediation committee which ironed out the misunderstanding. Because of the surgeon's failure to make an explanation, the assistant surgeon's bill was cancelled. In this case, the patient did not refuse to pay, but was dissatisfied simply because an explanation was omitted and a misunderstanding developed.

Another major cause of dissatisfaction with the medical profession has been the occasional inability to secure a physician in an emergency. For this reason, we have tried to establish emergency call services throughout the country. In this area we also have an educational responsibility to encourage all individuals coming into our communities to select a family physician before one is needed. It is quite fair for an individual to inquire whether or not a physician makes night calls. If the physician says he is a specialist and does not make night calls, then it is the right of the individual to select another physician who will provide this service.

It is also our responsibility to encourage patients to discuss with the physician services, fees, and what steps can be taken if the individual is dissatisfied. The physician should be willing to discuss with him the availability and operation of mediation committees. The doctor also should let the patient know that physicians are more interested in providing satis-

factory services than in the amount of money obtained for services rendered.

I want to read you an excerpt from a letter which I received after I had answered a critical letter: "Columbia University. Dear Mr. Brown: You were good enough to write me on October 21, regarding the excellent work you are doing. I had a personal experience that may interest you. A specialist did some work for my wife at her surgeon's request. I never saw the specialist, but thought his bill was high and wrote asking to discuss it with him. He was out of town and never got in touch with me. I wrote again, getting the enclosed answer. To the best of my recollection my request was a reasonable one and I had no desire to start any trouble. I still feel that his fee was extremely high. Other people just do not have doctors' incomes, at least not I." The doctor's reply was as follows: "Dear Mr. Harris: It is hard for me to understand what you are talking about with regards to the charge made for your wife. It was a request to do a certain procedure on her and I sent what is considered a nominal fee for this procedure. Obviously, your letter is an attempt on your part to escape paying medical expenses. I would suggest that in the future you arrange to have your wife treated as a ward patient as you do not care to incur the expense of private treatment."

The recipient penned this on the back of the doctor's letter: "I am an economics professor at Columbia University and am currently writing a text on economics. I want to call attention in my book to the AMA's program of discussion of fees. I shall not yield to the animal instinct in me to use this example as to how aspirations can be defeated."

This is a perfect example, in my opinion, of poor public relations.

Another individual wrote to Dr. Lull, saying: "I'm writing to you as I feel you should be best qualified to answer questions. What has become of the doctor of yesterday, who took the oath and lived up to it, dedicated himself to the saving of life rather than the almighty dollar, went on sick call anytime of the day or night instead of at his convenience, tended the sick first and asked for his fee later and concentrated on the advancement of medicine instead of on his bank account or social standing?"

I am sorry that such attitudes exist among the general public. There must be some basis for such accusations. If they have developed through misunderstanding, then it is our responsibility to invite a thorough discussion of services rendered.

According to the Seventh Annual Medical Economics Survey, physicians in this country donated \$410,000,000 worth of direct charity service last year. That is 12% of the total physician income during 1952. In addition, in direct contributions of money MDs gave \$90,000,000 and uncollected bills amounted to \$450,000,000. The amount of free services, cash donations and uncollected bills totals \$950,000,000. But just as our billions in European aid have failed to win the friendship of our European neighbors, this tremendous amount of free service has not won the increased friendship of the public. It is the spirit in which such service is given that really counts. We must make every effort to bring to the attention of the people the free services which the medical profession is rendering each year.

Another major criticism voiced against the medical profession is the apparent refusal of medicine to discipline its own members. You and I know that the number of thoughtless and unethical acts in medicine can be attributed to perhaps two to five percent of the profession. Yet, those acts condemn the entire profession.

Because some of our county medical societies have been reluctant to discipline their members, we leave ourselves open to continued public criticism generated by the acts of a few. We are in hopes that county societies will conscientiously remove from their membership roles all who are found guilty of constant violations of the code of medical ethics.

I was interested to learn at your own annual meeting this year that you had expelled some 640 members because they failed to keep up in their postgraduate work and therefore did not meet your membership requirements. Our county medical societies should be just as fearless in acting when individual physicians repeatedly violate our code of medical ethics. Otherwise, the great majority of ethical physicians will be burdened with criticisms caused by a few unethical men. We will never be able to make much progress with our public relations program unless we become fearless enough

to take these actions into account and do something about them.

There are a lot of doctors who say, "Oh, what difference does it make if I have good public relations or not? I'm getting along all right. My regular patients come to me." These men fail to consider the patients who fail to return because they were dissatisfied with the physician's services.

We are now preparing a little booklet on the physician's public relations. In order to get some good ideas for this booklet, we thought it was advisable to ask the profession for advice. We wrote to some 25 individuals throughout the country to get their suggestions. One physician in Arkansas wrote in turn to 25 other doctors within the state to get their opinions as to just how a pamphlet of this nature should be made up and what subject matter it should contain.

I'm sure you all took advantage of the little booklet we prepared on "Winning Ways with Patients," in which we tried to point out the various public relations techniques that should be explored and followed by your office secretary. The physician's public relations booklet will be quite similar.

I want to go over just briefly one of the letters regarding the physician's PR handbook. One physician offered these suggestions: "That we should keep in our mind our office management dealing with the physical aspects of a clean cheerful office, professional conduct, the handling of emergency night calls, the arrangement of substitute coverage, recognizing our own limitations, not selling ourselves short but always giving the best treatment possible, that our personal conduct in and outside the office has a relation to our public relations program, that we should do business within the town that we are receiving our income from, that we should pay our own bills promptly as we expect our patients to pay, that we should use special privileges only when they are warranted within the particular town, that we should keep informed on the scientific aspects of medicine, prepayment plans and organized medicine's policies, and that above all, we should be team players. Play on the team."

The suggestions he made for improving the public relations of the individual doctor included having a happy home, a good office assistant, carefully evaluating his patients and being decent and human to his fellow-men at all times. This physician says, "Sick people are emotionally upset. Families of patients are unreasonable, as you know only too well. Skill is no substitute for kindness. Treat people, not diseases." These were some of the suggestions given us by a practicing physician for improving medicine's public relations.

There is one other point I want to bring out and that is the fact that only half our team is playing. The men who regularly attend county and state medical society meetings are cognizant of our PR needs. But what about the hundreds within organized medicine who fail to realize the importance of such gatherings? The 40 to 60 percent who fail to attend county society meetings within the course of the year have little knowledge of the society's policies or activities. Often these are the men most critical of policies adopted, even though they failed to avail themselves of their opportunity to take part in formation of such policy. So I say that one of medicine's weaknesses is the fact that only about half our team is playing.

I am not going to discuss any of the activities of the American Medical Association insofar as its public relations program is concerned. I hope that if you have any questions about our program, you will feel free to discuss them with me.

In closing I want to say that it is our opinion we must do more than practice good medicine and good sound medical public relations—or even clean our own house for that matter. If we are going to maintain our free enterprise system in America, we are going to have to be willing to speak out in its behalf. You and I all know that the fight for people's minds is not over. Now is the time for medicine to help sell America back to Americans and encourage people to take an active interest in civic affairs. The medical profession should lead the way in this particular endeavor.

I want to leave with you one little verse, entitled "My Creed," which I believe exemplifies

the philosophy of medicine throughout the country:

"I do not choose to be a common man,
It is my right to be uncommon, if I can.
I seek opportunity, not security,
I do not wish to be a kept citizen,
Humbled and dulled by having the state look after me,
I want to take the calculated risks,
To dream, to build, to fail and to succeed.

I refuse to barter incentive for a dole,
I prefer the challenges of life to the guaranteed existence,
The thrill of fulfillment to the stale calm of utopia,
I will not trade my freedom for beneficence,
Nor my dignity for a handout.
It is my heritage to think and act for myself,
To enjoy the benefits of my creation
And to face the world boldly and say,
This I have done.
All this is what it means to me to be an American."

THE INTEGRATION OF THE GP IN THE HOSPITAL STAFF

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WHAT IS the position of the general practitioner on the staff of the modern hospital? In certain localities the general practitioner has no privilege whatsoever. The wisdom of this is open to question.

Good medical care includes a close direct relationship between physician and patient and a modern hospital should not disturb this basic ingredient of good care. The general practitioner is responsible for the largest percentage of patients admitted to the hospitals today and the recognition by the hospital of the general practitioner is essential. He should not only have privileges in all departments of the hospital but he should be able to do work in all departments in which he is qualified.

The "grass roots" of our present medical structure is the general practitioner. He knows medicine in all its ramifications. When an ill patient places his sick body in the hands of the family doctor, he does it confident that the proper procedure will be followed to get him well. This close personal relationship of patient and doctor is essential whether treatment is given in the home, office, clinic, or hospital. The doctor is expected to analyze, diagnose, treat, recommend consultation when needed, and he

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should follow the patient throughout his hospital stay regardless of which department he is in. This cements the doctor-patient relationship.

In many cases it is necessary to enter a patient in the hospital so that X-ray, electrocardiogram, laboratory equipment, etc. may be used in diagnosis. When the patient enters the strange surroundings at the hospital, he desires the same interest and care he enjoys before coming. If the service of a specialist is needed, the patient should have the benefit of the general practi-

tioner and specialist working together. This inspires confidence in the patient and adds to the personal interest which the patient feels is being given him.

The hospital of today provides the equipment and care needed for diagnosis and treatment. Since the days when the surgical department was the main unit of the hospital, many departments have been added that benefit the sick. The services now available are diversified. It is logical to assume that one group of doctors who use all services available should be a part of the complex organization.

The general practitioner is interested in all departments equally. He considers their importance in relationship to the patient. He and the patient are really the ones who must go into and come out of this maze of services, well and happy, for the hospital to meet the obligation for which it has been developed.

In many hospitals the patient has become a case rather than an individual. He no longer enjoys the personal relationship that he has previously enjoyed as the patient of the physician specializing in general practice. This situation can be corrected in large hospitals by giving proper status to the general practitioner on the staff. By so gaining the proper hospital privileges, he can keep the patient as an individual in whom he is personally interested and he can stand up for the rights of this individual against any group on the hospital staff. He, therefore, guards the patient-doctor relationship and coordinates the services that are available for the good of the patient in any large institution.

Case Histories Cannot Tell All

It may only be the general practitioner who knows the financial ability of the patient, the family's wishes, the stamina of the patient, the psychic disturbances which the patient has shown in previous illnesses, and many other observations which a family doctor will be aware of that very few case histories, no matter how well taken, would bring out. In this respect the general practitioner is as important in the diagnosing and treating, as any specialist could be. This art of practice which the general practitioner has so keenly developed, must be used if the patient is to be handled properly. This is the reason why a general practitioner

must be a necessary part in the hospital management of any patient.

There is no reason to assume that a patient can only suffer from one disease at a time. It becomes necessary to see the patient as a whole rather than for one condition. It is important often to coordinate services in different departments. It is an innovation in hospital procedure to medically and surgically treat simultaneously, by orthopedic consultation, the polio patient from the onset of the disease.

Except for Blue Shield our present form of hospital insurance shows that no attempt has been made to maintain this patient relationship with the general practitioner. If a patient is entered into a hospital and surgery is done only the surgeon is recognized financially, therefore giving the patient the impression that this is the important part of his coming to the hospital when really his own family doctor made the diagnosis and saw the need of a specialist. Actually it was the diagnostic shrewdness of the physician to whom the patient may owe his life. Why then should this all-important doctor-patient relationship be severed, or destroyed, or put in question? Why should not the general practitioner continue with the specialist in the care of the patient and both be recognized financially by the prepaid insurance? It would not lessen the respect of the patient for either but would enhance the value of both. The Blue Shield recognizes the importance of this and has changed its original policy to include both surgeon and general practitioner starting June 1, 1953.

Hospitals today are used not for emergency care only but they are used as a health center by the general practitioner for the diagnosis and treatment of disease.

The cost and size of modern diagnostic instruments make it prohibitive for the average practitioner to have these in his office. When the services of these are needed, the general practitioner should be able to hospitalize the patient for a time until he has completed use of them for diagnosis or treatment.

The majority of maternity cases today choose to go into hospitals for delivery rather than accept hospitalization only when pathological conditions make the services of a specialist advisable. The general practitioner delivers the

majority of babies and should be allowed the privilege of bringing his patients to the hospital without discrimination.

The hospital which provides equipment for better practice of medicine should have the services available to all qualified physicians rather than limit them to the use of specialists. To leave the running of a hospital to a chosen few specialists is to invite friction. To allow procedures to be established by a small group representing only a part of the medical profession is not in accord with good medical care or procedure. To allow this, is to lose sight of the basic principles of good medical care . . . the close personal relationship between general practitioner and patient.

It is a well known fact that for years smaller hospitals have been staffed almost exclusively with general practitioners who have worked in cooperation with hospital authorities for providing better medical care for patients.

The age of specialization has not diminished the need for the general practitioner. When general practitioners are found on the hospital staff, there has resulted not only more efficient medical care, but also an improvement in understanding between specialist and the general practitioner.

The Evolution of the Hospital

To clarify the changes that have come about in hospital management let us review hospital history.

The first hospitals were charity hospitals. The sick, the crippled, and the insane who were unable to pay for service at home were sent to the hospital. The death rate was high. The pest houses were among the first hospitals. All who could afford medical care preferred to be treated at home.

The second phase in hospital development came when a knowledge of bacteria was gained. After the knowledge of asepsis and antisepsis, the death rate in hospitals lessened. This was particularly true in surgery. It became an accepted practice for all, both millionaire and pauper, to go to the hospital for surgery when it was indicated. Medical illnesses were still largely treated in private homes.

The hospital administrator became aware that the hospital was changing from a charity or-

ganization to one catering to private patients. In order to sell their services to the public, the administrator glorified the doctor who was chiefly responsible for this change . . . the surgeon. Surgical cases filled the private wards of the hospital. The patient rejoiced at the surgical wonders performed at the hospital and both pointed with pride at recoveries.

It was in this same era that the hospital staff became established, with the surgeon elected the chief of staff. These first staff meetings were held usually once a year to place the seal of approval on the acts of the administrator.

The third step in development came when instruments of precision diagnosis were invented . . . such as . . . the X-ray, the fluoroscope, the electro-cardiograph, the basal metabolism machine. The services of a good laboratory for blood and pathology studies became essential.

When this equipment became standard procedure for diagnosis, then private patients came to the hospital for illnesses of a medical nature. Further advances in the past few years have increased the value of the hospital for diagnosis.

The fourth step in development came with the acceptance by the public that the hospital is a health center and that hospital care should include not only surgery, obstetrical care, medical care, and diagnosis, but also treatment of certain chronic diseases. The prepaid hospital insurance plans have made hospitalization possible for all financially. Living conditions today have made the services at the hospital a necessity rather than a luxury. The modern home is usually too small for the care of the invalid, and servants are hard to find. Private home nursing care is expensive and due to the nursing shortage, often unobtainable.

The size of hospitals has grown in the last few years. The modern hospital is a very complex group of different departments. This vast and complex service should be available to all. In order to coordinate these services, the place of the general practitioner has become more apparent.

Specific Examples Cited

The question arises as to the exact place of the general practitioner on the *large* hospital staff. The following are cited as examples of

hospitals in which this situation has been handled successfully.

The Christian hospital of St. Louis created a General Practice Department in the medical staff organization on December 1, 1947. Here the general practitioner may acquire privileges in all departments of the hospital and do any work there in which he has proved himself qualified. His qualifications and work are passed on by the professional relations committee.

This professional relations committee supervises work in clinics and recommends to the executive committee for improved service.

Any general practitioner desiring additional training is assigned a preceptor. His progress is followed and the committee then recommends when he is ready for full staff privileges.

The general practitioner with other members of the staff are responsible for training interns, residents, and nurses; the general practitioner participates in these programs according to interest, experience, and ability.

In Louisville, one large out-patient clinic has been established with 8 to 12 general practitioners in charge. When the patient is admitted, his history is taken, and he is examined by the intern under the supervision of the general practitioner. If a specialist is needed he is called. This system has worked well not only in teaching but in the establishment of a satisfactory doctor-patient relationship. The general practitioner can instruct the medical student in examination and diagnosis, and point out knowledge which he will need to know in private practice. From the standpoint of the patient there is this advantage. A complete examination is done on the first visit and consultation with the specialist given when needed. This means that usually the correct diagnosis is established on the patient's first visit to the clinic.

The third illustration is the Bethesda Hospital in Cincinnati. This hospital has 225 beds and 60 bassinets and in 1947 established a department of general practitioners. The hospital

provided the general practitioner with privileges enjoyed by members of any specialist department.

Members of the General Practice Department serve on clinic committees, credential committees, executive committees, intern training committees, medical record committees, nursing committees, staff service ceiling committees, operating room facilities committees, and assist in the nurse training program, by giving lectures to student nurses.

The members of the general practitioner's section on the hospital staff have been given responsibilities. In the cases mentioned, the professional, ethical, and personal standards of the general practice department are so high that it is an honor to have an appointment on the staff of the hospital in that department.

Conclusion

In conclusion, the position of the general practitioner in the modern hospital has assumed a place of importance not only in the small hospitals but in the *large* general hospitals and in teaching hospitals.

The modern hospital has many departments with complex and diversified services. The general practitioner should be able to coordinate services needed by the patient and do work in any department in which he qualifies.

Good medical care includes a continued close relationship between general practitioner and patient. A hospital should not disturb or sever this relationship during hospitalization of a patient.

The modern hospital acts as a health center and equipment for diagnosis and treatment should be available for all qualified members of the medical profession.

In cases where hospitals have instituted a general practitioner department there has resulted more efficient hospital service, higher patient morale, and better understanding between general practitioner and specialist.

CRITERIA FOR ADMISSION TO LARUE D. CARTER MEMORIAL HOSPITAL

JUUL C. NIELSEN, M.D.*

Indianapolis

ADMISSIONS to Indiana state hospitals during the year 1951-52 totaled 2,371 patients. It is evident from this total that Carter Hospital will never be able to admit all the mentally ill in the state of Indiana that need hospitalization, and since Carter Hospital serves the entire state, it is necessary to select the patients that will receive maximum benefit from treatment at the Carter Hospital facilities. Since our opening on July 28, 1952, for 25 patients, we have at this writing expanded our capacity to 100 beds. During that period 232 patients from 53 counties have been admitted for treatment. Of these patients, 90 are still in the hospital, 10 have been transferred to other state hospitals, and 132 have been discharged. During this same period of time, we have worked out admission procedures and we are now of the opinion that information in regard to these procedures and criteria for the selection of patients will be of value to the physicians and the courts of the State as well as other agencies that deal with mentally ill patients.

A patient can be admitted to Carter Hospital by three different methods: voluntarily, involuntarily, and by transfer. Admission blanks for voluntary and involuntary admission are to be obtained by writing the Admission Office, Carter Hospital. The procedure for voluntary admission is as follows: When the attending physician deems it advisable for his patient to be hospitalized at Carter Hospital, the physician contacts the Admission Office at Carter Hospital either by telephone or letter. The Admission Office will give him the necessary information and send him the proper form for voluntary admission. The physician will fill out the form, and with a summary of the case, return it to the Hospital, at which time the physician will be notified of the day and hour when the patient can be re-

A native Dane, Juul C. Nielsen, M.D., has been a naturalized citizen of the United States since 1918. Graduate of the University of Nebraska School of Medicine, he was in general practice for a short time before serving a residency in psychiatry at Norfolk State Hospital, Nebraska. He later became superintendent there and from 1933 to 1951 was superintendent of Hastings State Hospital, Nebraska. From 1942 to 1945 Doctor Nielsen served as a major in the Army Medical Corps. He's a member of several psychiatric organizations and author of articles dealing with his specialty.

ceived. In case the Admission Office finds that hospitalization isn't necessary or that hospitalization should be obtained elsewhere, this information and other recommendations will be forwarded to the physician so that the proper disposition of the patient can be made. Telephone calls can be best answered by the Admission Office between the hours of 8:30 a.m. and 4:30 p.m.

The procedure for involuntary admissions is the same as above with the exception that in some instances the court may require the admission papers, instead of the attending physician, and in some instances the arrangement for admission may be made through the court rather than by the attending physician, although most frequently, the arrangement for court hearing should be initiated by the attending physician. The great demand for hospitalization at Carter Hospital makes it unavoidable for us to maintain a waiting list which particularly precludes the possibility of emergency admissions at any time.

Transfers are accepted from state hospitals only on the recommendation of the superintendent of that hospital when he gives valid reasons for the transfer.

Since selection of patients is necessary, we have found it most practical to admit no one

* Medical Director, Indiana Council for Mental Health and superintendent, Larue D. Carter Memorial Hospital.

for a short period of time when they need long continued care; that is, treatment that lasts more than three months. For several reasons it is best that these be admitted directly to the state hospital. First, if the patient was initially admitted to Carter for a period of 60 to 100 days and it was evident that the patient would not recover for several months, it would be emotionally traumatic to the patient to be transferred to the state hospital of their district. It would tend to confirm the opinion of the patient that "Nothing can be done for me and that is why I am being transferred". Secondly, if the patient was admitted to Carter and treatment could not be completed here, much of the examination and workup of the case, as well as the treatment would have been wasted time and effort in that a good deal of the same work would have to be repeated at the state hospital. A third reason would be the expense of so many transfers in both time and money. A fourth reason would be that the work of the staff at the State hospital would be much less interesting and consequently it would be even more difficult to obtain and retain adequate staffs. Therefore, the Council for Mental Health has adopted the following policies for selection of patients to Carter Hospital:

1. The patient is a resident of the state.
2. The patient is over the age of 18.
3. The patient has a mental illness, the onset being less than six months previous to the referral and has not received any previous psychiatric hospital treatment.
4. Patients who belong to group number 3 who have had treatment but cannot continue the treatment for financial or other reasons.
5. Patients who are selected for teaching purposes.
6. Patients who have had previous mental illness of over 6 months' duration and who have responded to short term treatment at that time and where the physician feels treatment is indicated again.

Preference is given to patients from state hospitals that need special treatment at Carter and patients not eligible for other care such as

government hospitalization or private hospitalization, that is, the indigent or financially dependent group.

For the purpose of further clarification on the selection of patients, we found it useful to list a few of the diagnostic categories and types of problems that cannot be considered for hospitalization at Carter except under very unusual circumstances.

1. Patients below 18 years of age.
2. Mental defectives.
3. Chronic brain syndromes.
4. Sociopathic personality disturbance.
5. Alcoholic intoxication and addictions.
6. Boarding problems.
7. Patients that are known to require long term hospitalization, but who for one reason or another would prefer to spend 60 days at Carter Hospital before transfer.
8. Patients that have been hospitalized previously at some other state facility and have not been officially transferred with permission of the superintendent of the hospital.
9. Patients with whom we have had no contact by the physician before arrival.

Experience so far has taught us that by following these principles and procedures we will be able to offer the type of help to the patient that fulfills the needs of that patient for his recovery. Since the Carter Hospital is a teaching hospital, patients in the diagnostic categories that we have mentioned above would be needed on occasions in order to have a well rounded teaching program. A few patients from these categories can be admitted as teaching patients at the discretion of the superintendent.

The Carter Hospital has no wards for medical and surgical treatment; consequently, when patients are admitted who have conditions requiring such treatment they are transferred to the appropriate hospital at the Medical Center, most frequently Long Hospital. The arrangement for paying the bill while there is made in a similar manner as if the patient were sent directly from the County in the first place.

DOCTOR-PARENT RELATIONS

KEITH HAMMOND, M.D.

Paoli

ALTHOUGH an occasional general practitioner may end up after a certain number of years of hard work and study as a sort of prudently tempered Jack-of-all-specialties, even the average general practitioner usually finds quite soon that he must become at least a pediatrician of sorts. He may develop a little more than the usual interest in this phase of his practice. Even though he may gain an above-the-average acquaintance with the intricacies of illness in little babies and children, however, his academic training may not have educated him to the simple fact that a large part of his success in pediatric practice depends largely upon how satisfactorily he develops his doctor-parent relationship. Granted that he must know his pediatric P's and Q's, it is still a fact that its actual practice is largely a matter of mind over *mater*.

Whereas most of your practice hinges upon diagnosis and treatment, there is, in pediatrics, an equal emphasis upon prophylaxis, prognostication, and education. In the latter role you should drop your scientific jargon, become as homely and down to earth as a wet diaper, and start calling enuretics "bed-wetters" and speaking of epistaxis as a "nose bleed." You must forget that what seems simple to you is complicated to Mama, and if you want to sell her, for instance, on immunizations for Junior, you must assume your role of an educator and put her "hep" to the problem in terms she can understand.

When the doctor seriously assumes such attitudes as this discussion has thus far implied, it might be assumed that he ends up as only a folksy old family councilor with not too much needed above the eyes to keep in the business. However, this is strictly not the case. For instance, the doctor must be able to convince the old folks that even though Junior's sore throat and fever are gone after a single shot of penicillin he is really not out of danger. The physician must first know something of the latest concepts in prevention of rheumatic fever if he is to get the parents to cooperate and bring



"My hobbies include music, writing and just 'tinkering'", Keith Hammond, M.D., Paoli GP says, and substantiates at least one of the three with the statement that two of his articles have been published in the national publication, GP, and one of them rewritten for Sunday magazine supplement, Parade.

Native of French Lick, he started at DePauw, got his M.D. from I.U. School of Medicine in 1938, went to New Orleans to intern at Marine and Charity Hospital, spent some months at Chicago Maternity Center and in 1940 established practice in Paoli.

He took three and a half years out for military service, has four children, and has been an enthusiastic member of I.A.G.P. since it was organized.

their offspring back until it is really safe to discontinue treatment. Such knowledge is as professional, worthwhile, and valuable as the "know-how" of a gifted brain surgeon and may be even more life saving. It is not my intention to belittle the brilliant accomplishments in any of the more highly specialized fields of medicine and surgery, but I do mean to imply that the family doctor must keep on his intellectual toes and not be blind to the fact that his continuous acquisition of medical knowledge also saves lives. A baby dies just as dead of pneumonia as he does of a post-operative resection of a segment of Hirschsprung bowel.

Your role of family physician in the matter of prophylaxis of ailments of childhood includes not only immunizing procedures but also routine periodic health examinations and the giving of advice on everything from such dull questions as that of how long baby's belly band should be worn to the more interesting problem of what should be done about his fever spasms. In any case he spends about as much time explaining things as he does in doing things. As long as her young one's health is good, the

doctor's relations with mother are not nearly so frustrating as they become when her child looks sick. However, even well-baby care is the doctor's responsibility and it is up to him to get parental cooperation.

The maternal influence, of course, is felt more in your therapeutic endeavors than it is in your diagnostic efforts, although, as I shall point out later, Mama may even influence you in your efforts to reach a diagnosis.

I do not propose any delving into the profundities of psychiatry as it applies to motherhood, but it is necessary to elucidate a little along these lines to point out what I have in mind. Maternal attitudes, as is known to any reader of even a local rural weekly, profoundly affect the child. In this respect mothers can, in general, be classed in one of three groups. First, there would be the perfect mothers, whose attitudes would do nothing except promote the welfare of their children. These women are not mothers yet—have not had that first baby. Second, there are the seriously maladjusted mothers whose unwholesome outlook upon life and reactions to it may manifest itself in many queer attitudes toward her offspring and may, in turn, lead to seriously maladjusted children. The third group consists of those mothers whose attitudes may or may not seriously affect their children, but are usually of such a nature that they will overcome any handicaps in this respect and grow up to be generally accepted as "normal." It is this last group which includes the vast majority of mothers and it is they that we intend to consider here. In other words, these are mothers who are generally accepted as "normal" from a psychiatric standpoint.

One could spend pages delving into such subjects as reactions of the child to maternal rejection and even into the manifestations of rejection itself. However, it is not my intent to deal with any problems which are so serious as to demand that we steep ourselves this deeply in psychiatry. The children we are considering are either well or only physically ill and their mothers will not be seriously maladjusted, although I must admit that it may, at times, be difficult to say just where normality leaves off and abnormality begins.

Take the matter of maternal rejection, for instance. It is so common, especially during the child's babyhood, that a jubilant new gravida

five is as refreshing as a noon-day shower in August. This, of course, is not so serious as it sounds, because even maternal love may take a little time to develop. We have all seen the new mother who, in her uninhibited post-anesthetic moments following delivery, offers her child for free to any taker but who, a week later, wouldn't trade him for a career in Hollywood under any circumstances.

These Things, Too, Shall Pass

Such more or less minor rejection may become manifest even before baby arrives and lead to a state of constant anxiety on the part of the expectant mother with an excessive number of prenatal visits and frustrating telephone calls to her doctor. At first there is the constant conviction that she will miscarry. After she has passed safely through the first three or four months, vomiting persists or, if it has stopped, it is resumed. Fetal movements are excessive, painful, or otherwise upsetting, but near the last trimester they become weak and she decides that her baby has died *in utero*. Long before the little one has arrived his mother has added him to the ranks of the bottle-fed babies, only to suffer later from breasts painfully engorged with a copious supply of cow's milk substitute. You might even make a diagnosis of a feeding problem long before your little patient has even broken out of his amniotic membranes. Still, with all of this, the mother is not seriously maladjusted and, some 30 years later, her happy, successful, and well-balanced son may be declaring, in the words of Lincoln, and with all his sincerity, "all I am or ever hope to be, I owe to my darling mother." So, things are not as bad as they seem during babyhood and you can usually safely predict, during this trying time, that these things shall pass.

Since a diagnosis may often be reached by observation of objective signs, symptoms, and laboratory findings, parental cooperation has less to do with this phase of your practice than it does in therapeutic and prophylactic procedures. However, even here, have we not all been confused in a feeding problem, for example, when mother insisted that her child vomited everything she gave him? In such a case your own observation of a steady weight gain was perhaps your best proof that baby did not have a pyloric stenosis or some other serious disorder.

One must admit that it is somewhat more difficult for a doctor to maintain an objective and level-headed attitude in his efforts to arrive at a diagnosis when he is faced with a mother who gets the scent of lilies and carnations in her nostrils the minute Junior deviates from the baby-book specifications. Her excitement tends to be contagious. Still, even though you may be convinced of the frivolity of the child's ailment there is only one attitude to take toward the parents, and that is one of sympathetic understanding, always leaving the door open to further observation of the patient just in case you might be wrong! Then you will never have to face the embarrassment of having bid the parents goodnight with some remark about its being "nothing at all" only to be confronted the next morning with a sausage-shaped mass in their baby's abdomen. He might have only had the colic last night, but he didn't!

It Takes Art Plus Science

There is nothing we love to hear so much as that which we wish to hear, as witness the flourishing prevalence of quacks and charlatans. However, this is a psychological weakness which works both ways, and isn't it true that you dread to announce your prognosis to the parents when you find that their child has a stiff neck and muscular weakness along with his fever? Add to this the fact that the mother fearfully blinds herself to the situation and dwells upon irrelevant history and minor changes which she has noticed, and your prognosis may be based less upon sound judgment than it is upon hypnotic hope. Seriously, it is sometimes better to prepare the mother for the worst and then hope for the best. This is not quackery, but it may be a sound means of keeping the child under your care and observation. Then the child with early tuberculous meningitis, for example, might not be taken to a new doctor each day and finally have a diagnosis made by the one who eventually sees him when ominous tell-tale signs and symptoms have become established. In some

such cases it may be found that the first doctor was too rosy in his prognostication, when a gloomier outlook might have been an inducement to mother to keep her child under the original doctor's care and probably, on this account, have a diagnosis reached or suspected earlier. It is in such instances as these that your art ranks along with your science. We have all seen the doctor who lost some of his patients by death unnecessarily but retained the confidence of those who survived simply because he was long on art, even if he was short on science. Such a doctor would be an excellent physician if he retained his professional competence along with his bedside manner and refused to believe that which he hopes is true but which he knows is false.

The key to good doctor-parent relations lies largely in an understanding attitude on the part of the physician. However, I must admit that at times the keeping of an understanding heart would tax the moral strength of a fully inspired saint. Exasperating instances in any doctor's practice would fill a book full of incidences with a familiar "that's-just-what-happened-to-me" ring. There are the calls to the physician instead of the dentist in the wee hours because the latter was undoubtedly asleep and, says Mama, "I just hated to get him up." Have others had mother explain that she was afraid to put her baby on boiled water for fear it would scald his mouth? At such times as these, professional equanimity comes hard. It is simply a matter of maintaining tranquillity and suppressing any indignant outbursts with a self-reminder that you are seeing things through the calm eyes of a trained physician rather than the frightened eyes of a medically untrained parent. So the next time Mama goes into a long explanation of her baby's gastro-intestinal upset with lengthily dwelling upon how he vomits up his milk "all curdled and sour," humble yourself with the reflection that it took a hole in Alexis St. Martin's stomach and the brains in William Beaumont's head to help educate you along these same lines!

Memorandum on Annual Convention

June 29, 1953

To: Delegates, Councilors, Members of the Executive Committee and Officers of the Indiana State Medical Association

From: Headquarters Office, Indiana State Medical Association, 1021 Hume Mansur Building, Indianapolis 4, Indiana

Subject: CLARIFICATION OF TIMES OF MEETINGS DURING ANNUAL CONVENTION AND SUGGESTED HOTEL RESERVATION DATES

From a few reports reaching the Headquarters Office there is reason to believe there might be some confusion regarding plans for the meetings of the Executive Committee, Council and House of Delegates during the Annual Convention to be held at French Lick, October 18-21, 1953.

We have been informed that some of the delegates are making their room reservations for October 19, which is the first regular day of the convention. We believe that all members of the House of Delegates, Council, Executive Committee and officers will desire their reservations to begin on Sunday, October 18, 1953.

To remove any confusion that might exist we list herewith the schedule of meetings and times for the above groups.

EXECUTIVE COMMITTEE—12 noon luncheon, Sunday, October 18, 1953

COUNCIL — 3:00 p.m., Sunday, October 18, 1953

HOUSE OF DELEGATES — (first meeting) — Dinner 6:30 p.m., Sunday, October 18, 1953.

Please note that all of the above groups will meet on Sunday, October 18, 1953. If your reservation has been made beginning on the 19th of October, a letter to Mr. Prow, Reservation Manager, French Lick Springs, Indiana, requesting that it be moved up to October 18 will assure you of no difficulty upon arrival.

It might be of interest to you to know that as of June 17, 470 advance reservations had been received by the hotel. So if you have not made your reservation, it is advisable that you do so without further delay.

JAS. A. WAGGENER,
Executive Secretary.

Deaths

Norman E. Beckes, M.D., 80, who had been in practice in Vincennes for more than 50 years, died June 19 in Good Samaritan Hospital, Vincennes. Doctor Beckes was a graduate of Medical College of Indiana in 1897 and immediately established his practice in Vincennes. He served as an Army captain in World War I and had been elected Knox County coroner for four terms. Doctor Beckes was the father of Dr. Ellsworth Beckes, Vincennes. He was a member of Knox County Medical Society, a senior member of I.S.M.A. and American Medical Association.

N. Howard Thompson, M.D., 81, who was a practicing physician and surgeon for many years in Wabash, died June 29 in the Elks National Home, Bedford, Virginia, where he had resided for several years because of ill health. He was unmarried and had no close relatives. Doctor Thompson was a native of Wabash. He was a graduate of Rush Medical College, Chicago, and established his practice in Wabash following graduation in 1897. For a number of years he was associated with Dr. J. H. Ford, an early president of Indiana State Medical Association. He was a member of Wabash County Medical Society and a senior member of the state medical association.

Carl F. Briggs, M.D., 72, Sullivan physician for 51 years, died suddenly June 20 of a heart attack during the early hours of the morning. His family had left New York three days earlier for a tour of Europe. They returned immediately by plane from England.

Doctor Briggs was a 1902 graduate of Rush Medical College and established his Sullivan

practice soon after receiving his degree. He had served as secretary and president of Sullivan County Medical Society and was one of the founders of the R. H. Crowder Memorial Hospital. He was a member of Sullivan County Medical Society, Indiana State and American Medical Associations.

Daniel Dailey Jones, M.D., died June 11 in his home in Berne where he had been critically ill for three weeks. Doctor Jones, who was 82, had been in ill health suffering from arteriosclerosis since his retirement in 1951. He had practiced continuously in Berne since 1909 when he graduated from Northwestern University Medical School. A native of Ohio, Doctor Jones taught school near Berne before entering medical school. He served as a lieutenant-colonel during World War I in France and had a keen interest in veterans affairs at all times. For many years he practiced in partnership with his brother, the late Dr. H. O. Jones. Doctor Jones was a senior member of Adams County Medical Society, the Indiana State and American Medical Associations.

A former Evansville and Mount Vernon physician, **George W. Wilson, M.D.**, died June 10 at his Springfield, Missouri home. A retired Navy captain, Doctor Wilson was serving as psychiatrist at the Nevada, Missouri, state hospital. Born at Mount Vernon, Doctor Wilson practiced for one year following graduation from medical school in Evansville, served in the Army during World War I, returned to Mount Vernon for a year's practice and then entered the U. S. Navy, serving as a surgeon for 33 years, until his retirement two years ago. He was 61 years old.

News Notes

Dr. Richard McNabb, son of Dr. George McNabb, Carthage, has leased the offices and equipment of Dr. Ralph Dreyer at Knightstown. Doctor Dreyer is serving 18 months in the Navy and reports he has not made definite plans following his release from service. Doctor McNabb is a graduate of Indiana University School of Medicine and completed his military service before entering internship near Los Angeles, California. The deal for transfer of the offices was consummated as of July 1.

Spencer has a new general practice physician, **Dr. Donald Blackwell**, who will be associated with Dr. M. S. Brown. Doctor Blackwell, formerly of Bloomington, has just completed his internship at Indianapolis General Hospital

Dr. John F. Phillips, who has been in private practice of internal medicine in Fort Wayne, has joined the staff of the Caylor-Nickel Clinic, Bluffton. Doctor Phillips is a graduate of I.U. School of Medicine, served his internship at Lancaster, Pennsylvania, General Hospital, and his residency in internal medicine at Iowa Methodist Hospital, Des Moines.

Dr. Robert D. Pickett, who has been in practice in Indianapolis for four years, has been commissioned a captain in the air force and has reported at Montgomery, Alabama. Doctor Pickett is a native of Sheridan.

Dr. Robert A. Mino, who practiced in Evansville in 1946 and 1947, has returned to that city, establishing offices at 723 Mary Street. He has been certified as a diplomate of the American Board of Surgery. A graduate of Yale University School of Medicine in 1942, Doctor Mino interned in Wilmington, Delaware, and has since been in residency at Memorial Center, New York, served as chief resident surgeon at Memorial Hospital, Wilmington, and held a teaching fellowship at Hahnemann Medical College.

Dr. R. E. Greenburg has closed his offices in Jasper where he has practiced for three years and returned to active duty in the Navy.

Dr. F. Hugh Gootee, who has completed his internship at General Hospital, Indianapolis, has returned to his home community, Loogootee, and established practice. Doctor Gootee is a graduate of Loyola University School of Medicine, Chicago.

Accepting a residency appointment at Indiana University Medical Center, effective August 1, **Dr. Robert L. Witham**, closed his Culver office July 11. Doctor Witham had been in practice in Culver since May, 1947.

Dr. Donald C. Smith, a native of Mitchell, has moved from Hope to Columbus where he will occupy the offices of the late Dr. Thomas D. Carpenter. Doctor Smith, a graduate of Indiana University School of Medicine, served his internship at Wayne County General Hospital, near Detroit. He had been in practice in Hope for one year.

Dr. Byron S. Lingeman, who was graduated from I.U. School of Medicine in June, is serving his internship at Philadelphia General Hospital. He is the son of Dr. B. N. Lingeman, Crawfordsville.

Dr. Julius Glick, who has practiced medicine in Walkerton for the last 15 months, has left for Clinton, Iowa, for residence

Dr. Claude A. Hendrix, Jr., who has practiced at Waveland for three years, has been recalled to active duty with the U.S. Navy.

Dr. Kenneth R. Ockerman has moved from DeMotte to Rensselaer where he has established offices in the Johnson Clinic.

After completing four years of private practice in Washington, **Dr. H. R. Schroeder** has accepted a residency in the Louisville General Hospital and St. Joseph Infirmary, Louisville, where he will obtain an additional three years training in obstetrics and gynecology. He took the first two years of specialized training while in service. Doctor Schroeder plans to return to Washington.

Dr. Rodney B. Fruth, Connersville, left early in June for active duty with the U.S. Air Force Medical Corps. After a brief stay in Camp Gunther, Alabama, he will go to Weisbaden, Germany where he will be assigned to Air Force headquarters. Doctor Fruth has been in practice for the last three years with his father, Dr. Virgil J. Fruth, and will return to Connersville.

Indiana Nurses Fly to Brazil for ICN Congress

Seven Indiana nurses attended the Tenth Quadrennial Congress of the International Council of Nurses held in the Hotel Quitandinha, Petropolis, near Rio de Janeiro, Brazil, from July 12 through July 17.

The Indiana delegation, which made the trip by air, was headed by Helen Weber, Bloomington, president of the Indiana State Nurses Association. Others in the party were: Edith Adams, LaPorte; Muriel Hunt, Gary; Bernice Pearson, Peru; Mary Elizabeth Sales, Mrs. Inez Stierwalt and Irene Hanger, Indianapolis. More than 1,000 nurses from all parts of the world attended the congress. The 300 American nurses who attended made stops at Sao Paulo, Lima, and Buenos Aires to observe nursing schools and nursing services.

The International Council of Nurses is recognized by the World Health Organization as a consultative body on nursing.

Dr. A. Howard Fieldsteel, virologist who has held a fellowship in virology sponsored by the National Foundation for Infantile Paralysis at Children's Hospital, Cincinnati, for the last three years, has joined the research staff of Pitman-Moore Company, Indianapolis. Doctor Fieldsteel is a graduate of Johns Hopkins.

Heart Models Presented To Robert Moore Clinic

A new series of latex rubber models of normal and abnormal hearts, prepared by Abram Belskie, noted medical sculptor, has been presented to the Robert M. Moore Clinic at Indianapolis General Hospital by the Indiana Heart Foundation. Because there is difference between the contour and relative positions of the heart chambers before and after removal from the body it was thought worthwhile to construct this series of life-size hearts, normal and diseased. There are 10 models each separately mounted.

Dr. Sanford C. Snyderman and **Dr. E. H. Bergendahl**, Fort Wayne, have announced that they are now associated together in medical practice and have established offices at Room 629, Medical Center Building. Both are certified as specialist by the American Board of Otolaryngology.

The 31st annual scientific and clinical session of the **American Congress of Physical Medicine and Rehabilitation** will be held on August 31, September 1, 2, 3 and 4, 1953 inclusive, at the Palmer House, Chicago.

Scientific and clinical sessions will be given on the days of August 31 and September 1, 2 and 3. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association.

Full information may be obtained by writing to the executive offices, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

Dr. Robert F. Reed, 1952 graduate of I.U. School of Medicine, has entered the practice of medicine in association with Dr. James W. Ward in Mishawaka. Doctor Reed is a Marine veteran of World War II.

A.C.S. Clinical Congress to be Held in Chicago October 5-9

More than 11,000 surgeons, other physicians and guests are expected to attend the 39th annual Clinical Congress of the American College of Surgeons, the nation's largest scientific meeting primarily concerned with surgery, to be held in Chicago, October 5 through 9, 1953.

Surgical techniques and new developments in surgery will be covered in this five-day meeting. The program will include formal scientific papers, panel discussions, symposia, postgraduate courses, surgical forums, medical motion pictures, ciné clinics, color television and exhibits. Headquarters will be the Conrad Hilton Hotel. Dr. Thomas C. Douglass, associate professor of surgery, Northwestern University and attending surgeon, Passavant Memorial Hospital, is chairman of the Chicago Committee on Arrangements.

Dr. Harold L. Foss, president of the American College of Surgeons for 1953, will preside at the opening evening session at which Dr. Fred W. Rankin, Lexington, Kentucky, will be installed as president for the year 1954. Dr. Evarts A. Graham, St. Louis, chairman of the Board of Regents, will introduce special guests and Sir James Paterson Ross, London, England, will give the Eighth Martin Memorial Lecture, entitled "Science and Surgery."

Dr. Lewis E. Adkins has commenced his first year of resident training in general practice at Methodist Hospital, Indianapolis, which was made available through the General Practice Scholarship Award given by Mead Johnson and Company, pharmaceutical manufacturers at Evansville. Doctor Adkins, a native of Lebanon, Missouri, interned at Methodist after his graduation from Washington University School of Medicine, St. Louis, in 1952.

Dr. Harris B. Shumacker, Jr., Indianapolis, professor of surgery at I.U. School of Medicine, reported on results and progress of heart surgery in Indianapolis hospitals to the staff of Davis Clinic, Marion, on June 18. Members of Grant County Medical Society and surgeons from Wabash and Fort Wayne were present in addition to the clinic staff.

Dr. John B. Terveer has reopened an office in Decatur after serving two years as a captain in the United States Army. He was in Korea for one year and most recently was at Camp Atterbury. Doctor Terveer had practiced in Decatur for four years previously. He will occupy offices being vacated by Dr. Roland Reppert, who is retiring from practice to devote full time to his other interests, the Reppert Auction School and a Decatur real estate development.

Congress of Cardiology Scheduled for September, 1954

The Second International Congress of Cardiology will be held in Washington, D. C., September 12-15, 1954. It will be immediately followed by the Annual Scientific Sessions of the American Heart Association, September 16-18, 1954.

The Scientific Sessions lasting for three days will include formal papers, panel discussions, clinical pathological conferences and visits to important medical centers in Washington and Bethesda. The program will be printed in French, Spanish and English. Immediate translation of some of the papers and discussions will be made in three languages.

A series of Post-Congressional visits and conferences to at least 20 of the leading cardiac clinics in different parts of the U. S. and Canada has been arranged by special committees of local Heart Associations in the various cities.

Formal announcement of the detailed program will be made in October. Full details of plans, submission of papers for the program and other information may be obtained by addressing Dr. L. W. Gorham, Secretary-General, Second International Congress of Cardiology, 44 East 23rd St., New York, N.Y.

Dr. Stewart T. Ginsberg, who has been chief of professional services at the Marion VA Hospital for five years has been named manager of the new 956-bed neuropsychiatric hospital near Pittsburgh.

Another VA Hospital doctor, Louis M. Hohman, M.D., who has been chief of professional services at Indianapolis for five years, has been named manager of the 200-bed general medical and surgical hospital at Clarksburg, West Virginia.

Order Your Tickets for the
1953 Instructional Courses Now!

The complete schedule of classes for the 1953 Instructional Courses, offered as a special feature of the Annual Convention of the Indiana State Medical Association at French Lick Springs Hotel, is published below. All classes are on Monday, October 19.

(Postgraduate training credit will be given by the Indiana Academy of General Practice to members attending classes.)

Admission to each class will be by ticket. Classes are limited to 30 doctors. The cost is \$1.00 per class with a maximum charge of \$3.00 for three or more classes. Plan your course to include five classes and indicate second choices. Enclose your check made payable to Indiana State Medical Association.

Order now—classes are filled early!

INSTRUCTIONAL COURSE SCHEDULE
French Lick—October 19, 1953

Time	Course 1	Course 2	Course 3	Course 4	Course 5	Course 6
11 to 12	Infant Feeding Problems	Obstetric Emergencies	The Painful Shoulder	Convulsive Disorders	Gastro-Intestinal Bleeding	Treatment of Anemias
NOON RECESS						
1 to 2	Course 7 Demonstration of a Neurological Examination	Course 8 Pediatric Emergencies	Course 9 Some Common Errors in the Treatment of Fractures of the Extremities	Course 10 Treatment of the Neurotic	Course 11 Acute Abdomen	Course 12 Diagnosis and Treatment of Common Cardiac Disorders
2 to 3	Course 13 Proper Use of Electrolytes and Parenteral Fluids	Course 14 Poliomyelitis, early diagnosis and newer concepts	Course 15 Treatment of Burns	Course 16 Premarital and Marital Counseling For Women	Course 17 Management of Ano-Rectal Diseases	Course 18 Diagnosis and Treatment of Common Skin Disorders
3 to 4	Course 19 Diagnosis and Treatment of Common Skin Disorders	Course 20 Diagnosis and Treatment of Cardiac Disorders	Course 21 Clinical Uses of Radio-Isotopes	Course 22 Management of the Elderly Patient	Course 23 Management of Diabetes Mellitus	Course 24 Office Treatment of Common GU Diseases
4 to 5	Course 25 Management of Diabetes Mellitus	Course 26 Office Gynecology	Course 27 Common Peripheral Vascular Diseases	Course 28 Personal Economics for the Physician	Course 29 Dyspepsia	Course 30 Diagnosis and Treatment of Respiratory Diseases

Cut on Dotted Line

APPLICATION BLANK

Instructional Course Committee,
Indiana State Medical Association,
1021 Hume Mansur Building,
Indianapolis 4, Indiana.

Enclosed find check for \$1.00; \$2.00; \$3.00. Please reserve tickets for the following Instructional Courses:

First choice.....	11:00 A.M. No.:	1:00 P.M. No.:	2:00 P.M. No.:	3:00 P.M. No.:	4:00 P.M. No.:
Second choice.....	11:00 A.M. No.:	1:00 P.M. No.:	2:00 P.M. No.:	3:00 P.M. No.:	4:00 P.M. No.:

(Insert course numbers plainly, please.)

I will pick up my tickets at the Registration Desk, October 19, 1953.

Signed:M.D.

Address:

Next Year Please Include

Classes on These Topics

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22 Published Reports Covering Treatment of 1443 Peptic Ulcer Patients with Banthine

Comprising the reports published in the literature to date which give specific facts and figures of the results of treatment

AUTHORS	No. of Patients	Chronic, Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Complications ¹	Side Effects Requiring Discontinuance of Drug ²	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6 ¹			2			13
Bechgaard, Nielsen, Bang, Grunlund, Tobassen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34 ¹				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6 ¹			18			
Maier, Meili	38	38	24			14 ¹	27	7	4 ¹				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McDonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Brodors	60	60	58		1	1	35	19	6				10	1	49 ¹	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42 ¹									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Russell, Knox, Stephenson	146		141			5	146					4 ¹⁰	53			93
TOTALS	1443	968	1380	17	8	38	1142	132	131	12	26	54	552	52	179	634
PERCENTAGES		67.8	95.6	1.2	0.6	2.6	81.3	9.4	9.3			3.7	70.5	6.6	22.9	

1. Not included in tabulations.

2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."

3. Four had no symptoms when Banthine therapy was begun.

4. Of which seven were penetrative lesions and five partially obstructive.

5. No symptoms were present in four.

6. Two with symptoms only; no demonstrable ulcer.

7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.

8. Roentgen findings: after treatment period of two weeks; forty-seven had duodenal deformity.

9. All returned to work within a week.

10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past three years, more than 250 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 783 patients on whom reports were available.

In all but 9.3 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.



*Volume containing complete references, with abstracts of 39 additional reports, will be furnished on request by

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P. O. Box 5110, Chicago 80, Illinois

Society Reports

MINUTES COMMITTEE ON MATERNAL AND CHILD HEALTH INDIANA STATE MEDICAL ASSOCIATION

Abe Martin Lodge, Brown County, Indiana

May 24, 1953

Members Present: A. W. Cavins, M.D., Chairman, Presiding, Terre Haute; Reuben Allen Craig, M.D., Kokomo; Wilfred Brockman, M.D., Corydon; C. Curtis Young, M.D., Evansville.

Guests Attending: Kenneth D. Schneider, M.D., Brown County; Robert M. Seibel, M.D., Brown County; Ralph F. Bowman, Jr., M.D., Indiana State Board of Health; Jeanne E. Rybolt, M.D., Indiana State Board of Health.

I. Discontinued Programs:

The Committee was told that both the Unmarried Mother's Program and the Premature Infant Care Program for Camp Atterbury will be discontinued as of June 30, 1953. The Committee unanimously approved this action.

II. Premature Program:

- A. The Committee reiterated its recommendation that the Maternal and Child Health Division emphasize premature infant care in its institutes for nurses and other hospital personnel.
- B. The Premature Institute in Evansville for June 4 was announced.
- C. The material concerning premature infant care was presented to the Committee on Maternal and Child Health, read, corrected and approved. This included the following:
 1. "Medical Care of Premature Infant"
 2. "Instructions for Public Health Nurses"
 3. "Instructions to Parents"
 4. "Infant Formula Preparation at Home by Terminal Sterilization"
- D. It was recommended that the approved literature be sent to:
 1. All hospitals in Indiana with Departments of Obstetrics (c/o Hospital Superintendent).
 2. To secretaries of local medical societies.
- E. It was recommended that the "Medical Care of Premature Infants" be printed in the Indiana State Medical Association Journal with an introductory paragraph explaining:
 1. How the literature will be used,
 2. Where reprints may be obtained,

3. That the literature is a summary of thought on the subject at the present time,

4. That it has been compiled by the Committee on Maternal and Child Health of the Indiana State Medical Association and the Division of Maternal and Child Health of the Indiana State Board of Health as part of an effort to reduce the incidence of premature death in the State of Indiana.

The article will be followed by a list of incubators that are approved by the Council on Physical Medicine of the American Medical Association.

The sample article will be sent to Doctors Cavins, Brockman, Craig and Young for approval.

III. Brown County Maternity Service:

- A. The Brown County Midwifery Service in Nashville was visited by the Committee members. Mrs. Catherine Lory, nurse-midwife, explained the service and answered the Committee's questions.
- B. The Committee reconvened in the offices of Doctors Schneider and Seibel in Nashville. Doctors Schneider and Seibel stated that they felt that Mrs. Lory had met a definite need in Brown County. However, the two doctors felt that the service presented the following problems:
 1. There is need for a social service work-up on each patient prior to delivery to determine the indigency of the patient.
 2. There is need for a survey to compute the average cost per patient delivered by the midwife.
- C. The Committee joined Doctors Schneider and Seibel in commending Mrs. Lory for the service that she has rendered Brown County. A question was raised about the Midwifery Service and its value in future years, for Mrs. Lory plans retirement in the near future. The following questions were asked:
 1. Why was the Brown County Midwifery Service established?
 2. How has it functioned?
 3. How many deliveries have there been in Brown County per year since this service began?
 4. How many deliveries have been done by Mrs. Lory per year?

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5. How many maternal and infant deaths were there prior to this service and for each year since the service began in Brown County?
6. Has there been a progressive decrease in the number of home deliveries in recent years?

It was suggested that Dr. Rybolt, Acting Director of the Division of Maternal and Child Health of the Indiana State Board of Health, compile answers to these questions in report form which would be sent to all Committee members.

- D. It was recommended that copies of the Policies and Procedures for the Brown County Midwifery Service be sent to Doctors Schneider and Seibel.

IV. Maternal and Child Health Division Activities: Dr. Cavins read a letter from the Maternal and Child Health Division which related the Division's activities in the past six months period of time.

V. Rheumatic Fever Program:

Preliminary plans for a rheumatic fever pilot study for Columbus, Indiana were announced. This study will be a joint project of the Heart Foundation, Division of Gerontology and Chronic Disease and the Division of Maternal and Child Health of the Indiana State Board of Health. This study will be the first of several for Indiana and emphasis will be placed upon the prevention and the diagnosis of rheumatic fever. The study will **not** include the treatment of rheumatic fever. The patient will be returned to his family physician for therapy and care.

The meeting was adjourned at 4:45 p.m.

MINUTES

**Fourth Meeting, Liaison Committee of
American Legion, Department of Indiana,
Indiana State Medical Association, Indiana
State Dental Association and Indiana State
Hospital Association**

Antlers Hotel, Indianapolis, May 17, 1953

Meeting was opened at 2:30 P.M. with the Indiana Hospital Association hosts with Mr. E. J. Shea, President of I.H.A. presiding. Present were:

American Legion: Mr. William O'Neill; Mr. Frank Myers, Department Adjutant; Dr. Norman R. Booher; Mr. Nick Lynch, National Field Service; Mr. B. A. Brooks, National Field Service; Mr. John K. Chappell, Department Commander.

Indiana State Medical Association: Dr. Maurice Glock; Dr. Dan Talbott; Mr. James Waggener, Executive Secretary.

Indiana Dental Association: Dr. G. T. Gregory;

Dr. Rollie Bennett, 517 Anderson Bank Bldg., Anderson.

Indiana Hospital Association: Mr. Ed Shea.

Dr. Gregory introduced Dr. Bennett as his successor on the committee, and excused himself.

Minutes of third meeting March 15, 1953 read and accepted.

Nick Lynch distributed copies of results of seven surveys run recently by Legion on non-service-connected cases in Bath, N.Y., Oklahoma City, Boise, Sioux Falls, Providence, R.I., Erie, Pa., Altoona, Pa. Stated results on some more are in process of mimeographing.

Mr. Lynch made some remarks on preliminary observations of surveys, so far.

Dr. Glock asked about certain questions on the surveys.

Dr. Booher pointed out that much good information is contained in these.

Dr. Talbott felt much good information is contained in surveys but suggested that the committee make some recommendations to pin point information on these surveys. Felt cases admitted for acute diagnosis from domiciliary homes should show reasons for membership in domiciliary; that type of disability be made more specific; and that remarks column be made broader; that complete census of non-service-connected cases in each hospital be presented for day of survey with diagnosis of that group. It was further suggested that AMA and other non-veteran groups take more active part in these surveys. Talbott moved adoption of above, seconded by O'Neill and passed.

Question next discussed was projected survey of Indiana V.A. Hospitals, other than Marion. Mr. Lynch stated Legion Field Service would do this and would accept suggestions as to procedure and questions to be asked.

Dr. Talbott made motion that surveys be made on **Indiana Veterans on non-service-connected GM&S cases** in two Indianapolis hospitals, Ft. Wayne, Hines and Louisville Hospitals. Seconded by Booher. Passed.

Booher made motion that Field Service of Legion making Indiana surveys be joined by representative of I.S.M.A., I.H.A. and I.D.A., above motion made with understanding the permission of Central office of V.A. must be secured and each participating group represented must agree to participate. Seconded by Glock. Passed.

Specific items on questionnaire to be used in Indiana discussed. Mr. Lynch passed out actual survey sheets, previously used, to committee. Thought was expressed that questions were O.K. but that reporting in compilations should be expanded.

It was agreed that the questionnaire be submitted to each participating organization for approval and suggestions and that this approval

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and/or suggestions be submitted to Mr. Frank Myers; and when completed, be sent by Mr. Myers to members of Liaison Committee who will vote by mail to approve any suggestions submitted or other recommended action, these opinions then to be sent back to Mr. Myers who will transmit these majority-approved suggestions to the Director of the American Legion Field Service. In addition, each participating organization will submit the name or names of their members who will participate in the survey at each of the five surveys to be run on Indiana Veterans in Indianapolis Hospitals, Fort Wayne, Hines, Illinois and Louisville, Kentucky and dates arranged for the surveys.

Secretary of Committee instructed to ask permission for the above surveys from Central office of V.A.

Question of intermediate type beds was discussed. Mr. O'Neill pointed out that cost of Veterans' hospitalization could be cut by this plan. Mr. Shea promised to get information from A.H.A. on this problem and get opinion of his group and report back at the next meeting on this subject. Dr. Booher stated Legion is for intermediate type beds.

Dr. Booher brought to the attention of the committee the proposed admission plan for psychiatric patients of the V.A. of April 21, 1953.

Dr. Bennett brought up question of V.A. dental program. Discussed the details of the program, especially as concerned out-patient care, under P.L. 2, 73rd Congress. Pointed out methods used in Canada to terminate service-connected dental care. Was asked to bring more information to next meeting.

Mr. Shea asked for host and date of next meeting. Dr. Glock moved next meeting be held on **Wednesday, September 9, 1953 at 2:30 P.M.** Seconded by Mr. O'Neill. Passed. The Legion offered to be hosts and offer was accepted.

Dinner served in Coral room and meeting adjourned at 7:00 P.M.

COUNCILOR DISTRICT MEETING

THIRD COUNCILOR DISTRICT

Dr. R. Arnold Griswold and Dr. Laman Gray, both of Louisville, and Dr. Ralph Smith, Vincennes, were speakers at the scientific session of the Third District Medical Society June 17 in the French Lick Springs Hotel. Doctor Griswold spoke on "Surgery of Peptic Ulcer"; Doctor Gray on "Cancer of the Cervix" and Doctor Smith discussed "Pitfalls in the Diagnosis and Treatment of Angina Pectoris".

At the dinner meeting for members and guests, Mr. Sam Rosenberg spoke on "Young Men of Action."

Dr. Edward J. Ploetner, Jasper, was named district president for the coming year and the date of the next annual district meeting was set for May 26, 1954 in Jasper.

Dr. Paul D. Crimm, Evansville, president of the Indiana State Medical Association, and James A. Waggener, executive secretary, attended the meeting.

LOCAL SOCIETY REPORTS

Crawford-Harrison County Medical Society met June 4 in the Harrison County Hospital at Corydon for dinner and an informal discussion of cases, rates, rural practice problems and general information concerning the area. The discussion was planned to assist Dr. Claude Davis, who is establishing his practice in Milltown. Six members were present.

Dr. J. F. Treon, son of Dr. James F. Treon, Aurora, was the guest speaker June 18 at the meeting of **Dearborn-Ohio County Medical Society** in the Dearborn Country Club. Doctor Treon is with the Kettering Laboratories and was asked to discuss the work of the laboratories and school as a special gesture to his father who completed 50 years of practice in June. Eleven members held an informal round table discussion following Doctor Treon's talk.

Fifteen members of **Franklin-Fayette County Medical Society** met in the Mounds Hotel, Brookville, June 9. Dr. William Chambers, Cincinnati, presented a paper on "Colon Conditions". The business meeting of the society was deferred until the following hospital staff meeting.

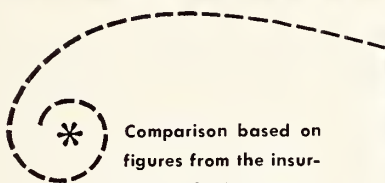
The **Gibson County Medical Society** reported 15 members present for the June 8 meeting in the Emerson Hotel, Princeton, when Dr. Robert J. Rohn, Indianapolis, gave a paper on

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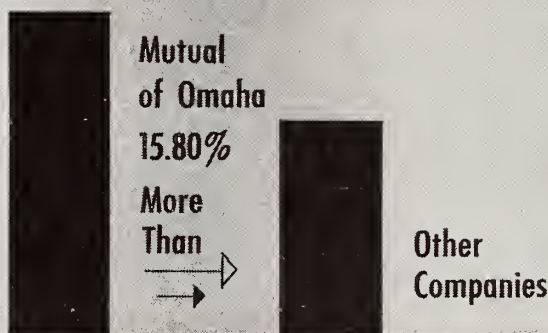
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Mutual of Omaha's 1952 Dr. C. C. Criss Award — a gold medal and \$10,000 — was presented to Howard A. Rusk,

M.D. (center), by V. J. Skutt (right), president of Mutual of Omaha, at the Annual Dinner of the American College of Physicians at Atlantic City, April 16, 1953. Looking on is T. Grier Miller, M.D. (left), president of the College. Dr. Rusk, professor and chairman of the Department of Physical Medicine and Rehabilitation at New York University College of Medicine, was selected for his outstanding work in rehabilitation. The award is a memorial to the late C. C. Criss, M.D., founder of Mutual of Omaha.

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"Hematology". There was no formal business meeting.

Perry County Medical Society members met in the county nurse's office in Cannelton June 2 for a business meeting. The eight doctors present voted in favor of the resolution to abandon the interim meeting of the House of Delegates of I.S.M.A. Pledge cards for the Medical Education Fund were distributed and discussed and plans made for the next program when the film "Without Fear" will be shown by Robert Amick, field secretary.

Eleven members of Rush County Medical Society met in the Rush County Hospital June 11 for a dinner meeting and general discussion of hospital problems.

Dr. C. W. Atkinson, Boswell, who celebrated 50 years in the practice of medicine on May 11, was honored by the Benton County Medical Society at their May 21 meeting in the Country Club at Fowler. The Society presented him with a new electric clock for his office.

INDIANA STATE BOARD OF HEALTH Division of Communicable Disease Control

MONTHLY REPORT—JUNE 1953

Disease	June 1953	May 1953	Apr. 1953	June 1952	June 1951
Animal Bites	336	427	161	—	—
Chickenpox	112	511	513	143	82
Conjunctivitis	28	67	56	5	3
Diphtheria	6	3	3	2	10
Dysentery, Amebic	13	8	—	3	3
Dysentery, Other or Unspecified	3	12	6	—	3
Encephalitis	1	—	—	6	2
Food Infection	1	2	2	2	1

Impetigo	7	6	6	3	3
Infectious Diarrhea	16	2	2	5	—
Infectious Hepatitis	97	127	106	34	20
Infectious					
Mononucleosis	2	5	6	—	—
Influenza	25	61	224	3	23
Measles	1,348	2,198	813	538	374
Meningitis,					
Meningococcal	7	18	18	4	2
Other	3	5	—	6	5
Mumps	146	405	185	158	183
Pneumonia	12	48	46	34	52
*Poliomyelitis	17	12	11	19	12
Psittacosis	1	—	—	—	1
Rabies in Animals	40	55	27	20	63
Rheumatic Fever	3	8	5	1	1
Rocky Mountain Spotted Fever	1	—	—	—	2
Salmonella Infections	8	1	—	—	—
Streptococcal Infections	71	226	226	46	43
Tetanus	1	1	—	2	1
Tinea Capitis	2	20	8	1	—
Tularemia	1	—	2	—	—
Typhoid Fever	2	1	5	3	2
Vincent's Infection	5	4	5	—	8
Whooping Cough	65	49	21	30	97

* Delete one (1) case of poliomyelitis from month of March (duplicate).

Books

TEXTBOOK OF SURGERY. By H. F. Moseley, M.A., D.M., M.Ch. (Oxon), F.A.C.S., F.R.C.S. (Eng.), F.R.C.S.(C), Assistant Professor of Surgery, McGill University; Associate Surgeon, Royal Victoria Hospital, Montreal, Canada, Editor, and others. Cloth. pp. 896, with illustrations. \$15.00. The C. V. Mosby Company, St. Louis, Missouri, 1952.

This text represents the combined efforts of 28 collaborators, most of whom are from the Staff of McGill University and the Royal Victoria Hospital of Montreal. The book is written in clear straightforward manner and is well illustrated for the most part by simple line diagrams. A refreshing addition is the use of many colored diagrams and plates by Dr. Frank H. Netter. The sections on basic science are particularly good and those on thoracic surgery, hernia, gastro-intestinal surgery including gall-bladder and esophageal surgery are particularly good. The volume should make a popular text for medical students and hospital house staffs. Although this work is the result of numerous collaborators, the total contribution constitutes an exceedingly well integrated-work. No attempt is made to cover in great detail the surgical pathology, anatomy and physiology associated with all of the conditions described, and the surgical subspecialties of the eye, ear, nose and throat, and gynecology are not dealt with because they are usually treated in special texts. The outline of the text offers a practical approach to the training of medical students in the surgical principles and techniques. C.S.C.



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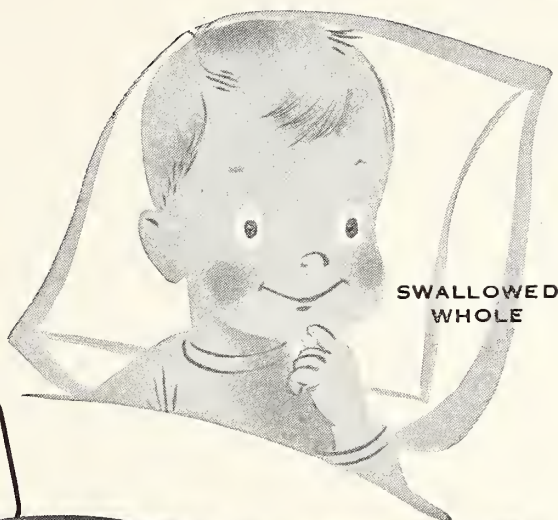
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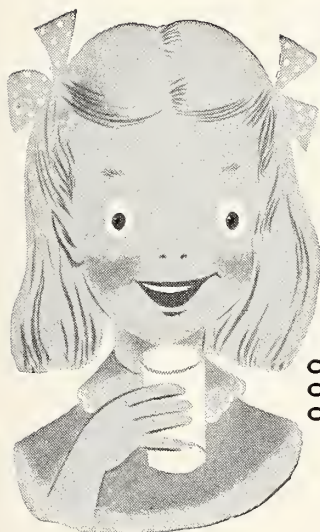


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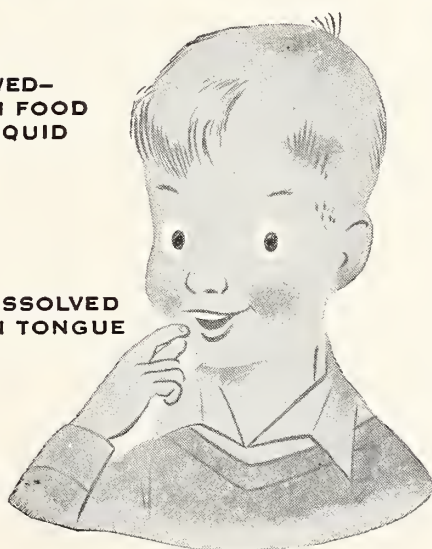
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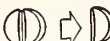


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Memorandum on Annual Convention

To: Delegates, Councilors, Members of the Executive Committee and Officers of the Indiana State Medical Association

From: Headquarters Office, Indiana State Medical Association, 1021 Hume Mansur Building, Indianapolis 4, Indiana

Subject: CLARIFICATION OF TIMES OF MEETINGS DURING ANNUAL CONVENTION AND SUGGESTED HOTEL RESERVATION DATES

From a few reports reaching the Headquarters Office there is reason to believe there might be some confusion regarding plans for the meetings of the Executive Committee, Council and House of Delegates during the Annual Convention to be held at French Lick, October 18-21, 1953.

We have been informed that some of the delegates are making their room reservations for October 19, which is the first regular day of the convention. We believe that all members of the House of Delegates, Council, Executive Committee and officers will desire their reservations to begin on Sunday, October 18, 1953.

To remove any confusion that might exist we list herewith the schedule of meetings and times for the above groups.

EXECUTIVE COMMITTEE—12 noon luncheon, Sunday, October 18, 1953

COUNCIL — 3:00 p.m., Sunday, October 18, 1953

HOUSE OF DELEGATES — (first meeting) — Dinner 6:30 p.m., Sunday, October 18, 1953.

Please note that all of the above groups will meet on Sunday, October 18, 1953. If your reservation has been made beginning on the 19th of October, a letter to Mr. Prow, Reservation Manager, French Lick Springs, Indiana, requesting that it be moved up to October 18 will assure you of no difficulty upon arrival.

It might be of interest to you to know that as of June 17, 470 advance reservations had been received by the hotel. So if you have not made your reservation, it is advisable that you do so without further delay.

JAS. A. WAGGENER,
Executive Secretary.

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"THE STORY OF MEDICINE IN ART"

AN ART EXHIBIT of unusual scope which will tell the story of the close relationship of medicine and art down through history will open September 11 in the Milwaukee Art Institute and continue through October 25. The State Medical Society of Wisconsin and the Boston Store, Milwaukee department store, are co-sponsors.

This is believed to be the first exhibition of its kind in an art museum in the United States. Planning has been done over a long period and the actual exhibit has been in preparation for two years.

The entire Milwaukee Art Institute will be turned over to the exhibit with various areas of the building devoted to specific topics.

Main topics will include: Medicine in War; The Doctor; Therapy; The Human Body; Cure of Disease; Life Cycle; Intoxication; Diseases and Prevention; Insanity; Quackery and Superstition; Scientific Section; Pharmaceutical Section; Medicine and Religious Beliefs. Some of

these will be subdivided into more specific topics.

Items have been borrowed from museums throughout the United States, from medical colleges and universities, from individual art collectors, medical illustrators, sculptors, pharmaceutical concerns, collectors of rare manuscripts, books, coins, medals, stamps and in many cases from the artist himself.

Works of contemporary artists will be found mingled with those of the old masters—Rembrandt, Daumier, Dürer, Hogarth, and many others.

A catalogue will be available listing all items, lenders, with illustrations and the story of the exhibit.

Medical men and medical historians from throughout the nation are cooperating and will help provide a series of lectures for the professional and the layman during the period of the exhibition.

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The Knox "Eat and Reduce" Plan is a simple, sensible regimen that places no burden of exercise or hunger on the patient. Quite the contrary, it permits three tempting, solid meals daily, plus between-meal feedings. The menus have been carefully selected so as to provide an abundance of vitamins, minerals and protein. Many of the dishes utilize Knox Gelatine, which is, of course, all protein and no sugar—thus being an effective aid in weight reduction.



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Address.....

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Three New Staff Doctors At Norways Hospital

Norways Foundation Hospital, Indianapolis, has announced that three doctors joined the resident staff at the hospital during July.

Dr. W. Arthur Blair, graduate of Queen's University, Kingston, Ontario, will complete his third year of psychiatric residency at Norways beginning July 12. He served his second year at Rochester State Hospital, Rochester, New York.

Dr. John P. McNamara, who has been in private practice in Indianapolis for five years, began his first year psychiatric residency July 1 at Norways. He is a graduate of St. Louis University School of Medicine.

The third addition to the staff, Dr. James Floyd Carlin, is a graduate of Western Reserve University in Cleveland and has just completed his internship at St. Luke's Hospital.

Norways Foundation Hospital

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(2) National Research Council—*Recommended Dietary Allowances*, Reprint 129, (1949)

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Fellowships Offered by Arthritis, Rheumatism Foundation

The Arthritis and Rheumatism Foundation is offering the following research fellowships in the basic sciences related to arthritis:

1. Predoctoral fellowships ranging from \$1,500 to \$3,000 per year, depending on the family responsibilities of the fellow, tenable for one year with prospect of renewal.
2. Postdoctoral fellowships ranging from \$3,000 to \$6,000 per annum, depending on family responsibilities, tenable for one year with prospect of renewal.
3. Senior fellowships for experienced investigation will carry an award of \$6,000 to \$7,500 per annum and are tenable for five years.

Deadline for applications is November 1, 1953 and applications will be reviewed and awards made by February 15, 1954. Information and application forms may be obtained from: Medical Director, The Arthritis and Rheumatism Foundation, 23 West 45th Street, New York 36, New York.

COOK COUNTY GRADUATE SCHOOL OF MEDICINE

Postgraduate Courses—1953

- SURGERY**—Intensive Course in Surgical Technic, Two Weeks, starting September 14, September 28, October 12.
Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting October 26.
Surgical Anatomy & Clinical Surgery, Two Weeks, starting November 9.
Gallbladder Surgery, Ten Hours, starting October 26.
General Surgery, One Week, starting October 5.
Surgery of Colon & Rectum, One Week, starting September 21.
Basic Principles in General Surgery, Two Weeks, starting September 21.
Thoracic Surgery, One Week, starting October 12.
Esophageal Surgery, One Week, starting October 19.
Breast & Thyroid Surgery, One Week, starting October 26.
Fractures & Traumatic Surgery, Two Weeks, starting October 26.
- GYNECOLOGY**—Intensive Course, Two Weeks, starting September 21.
Vaginal Approach to Pelvic Surgery, One Week, starting November 2.
- OBSTETRICS**—Intensive Course, Two Weeks, starting October 5.
- DERMATOLOGY**—Intensive Course, Two Weeks, starting October 19.
- MEDICINE**—Electrocardiography & Heart Disease, Two Weeks, starting October 12.
Intensive General Course, Two Weeks, starting September 28.
Gastroenterology, Two Weeks, starting October 26.
Allergy, One Month and Six Months, by appointment.
- CYSTOSCOPY**—Ten-Day Practical Course starting every two weeks.
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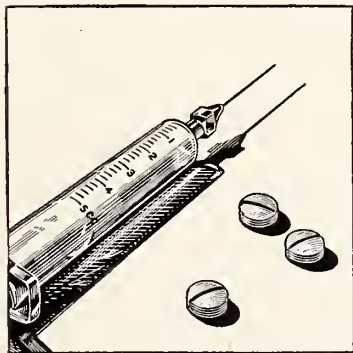
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I.S.M.A. PHYSICIAN PLACEMENT SERVICE LISTS OPPORTUNITIES AND REQUESTS

IN A CONTINUING PROGRAM to attract more doctors to Indiana, the Physician Placement Service of the Indiana State Medical Association begins, with this issue of *THE JOURNAL*, the publication of a list of doctors interested in Indiana locations and a list of Indiana communities which are seeking new doctors. Additions to the lists will be published as they are received.

Names and addresses of doctors together with their preference as to type of practice, or their specialty if they have been certified, will be furnished. Communities will be identified by name, county and population. The name of the individual or organization to contact also will be given.

This latest service of the Physician Placement Service of the Rural Health Committee of I.S.M.A. is inaugurated with the hope that better distribution of medical service to citizens of Indiana will be obtained. Any doctors now practicing within the state who are interested in any

of the listed openings for physicians are invited to contact the headquarters office of Indiana State Medical Association for additional information and assistance.

It is emphasized by the Rural Health Committee that the lists must be reasonably current to be valuable. Doctors who select a new Indiana location and communities which solve their doctor shortage should notify the I.S.M.A. headquarters office immediately to withdraw such names from the lists.

The following requests for locations and for doctors have been received since January 1, 1953:

Name and Address of Physician	Type of Practice Desired
Joseph L. Steinem, M.D. (Available 12-53) 9260 Coleman Ave Norfolk, Virginia	General practice—public health
Ralph W. Jacobs, M.D. 90 Paso Robles Drive Santa Barbara, California	General practice
W. P. Skirball, M.D. 1028 Columbus Sandusky, Ohio	Internal medicine
James E. Chapman, M.D. 521 Donmanton Blvd. Alexandria, Virginia	General practice
Jack L. Titus, M.D. 36060 Glenn Street Wayne, Michigan	General practice
H. W. Snodgrass, M.D. Jackson Memorial Hospital Miami 36, Florida	Surgery
F. L. Mendez, Jr., M.D. The Buffalo General Hospital Buffalo, New York	Surgery

(Continued on Page 840)

Some questions about filter cigarettes that may have occurred to you, Doctor

and their answers by the makers of

Kent

Q: What materials are used in cigarette filters?

A: Until just recently, cellulose, cotton or crepe paper were the only materials used in cigarette filters.

Now, after long search and countless experiments, KENT's "Micronite"* Filter has been developed. It employs the same filtering material used in atomic energy plants to purify the air of minuteradio-active particles.

Q: How effective are these cigarette filters?

A: Scientific measurements have proved that cellulose, cotton or crepe paper filters do not take out a really effective amount of nicotine and tars.

However, these same tests also have proved that KENT's exclusive Micronite Filter *approaches 7 times the efficiency of other filters in the removal of tars and nicotine* and is virtually twice as effective as the next most efficient cigarette filter.

Q: Do physiological reactions to filter cigarettes differ?

A: The drop in skin temperature occurring at the finger tip induced by filtered cigarette smoke was measured according to well-established procedures.

For conventional filter cigarettes, the drop was over 6 degrees. For KENT's Micronite Filter, there was no appreciable drop.

Q: Does an effective cigarette filter also remove the flavor?

A: KENT's Micronite Filter . . . the first cigarette filter that really works . . . lets smokers enjoy the full pleasure of a really fine cigarette, yet gives them the greatest protection ever from tars and nicotine.

In less than a year's time, the new KENT has become so popular it outsells brands that have been on the market for years.

takes out up to 7 times more

nicotine and tars—

leaves in full, rich tobacco flavor.



I.S.M.A. Placement Service Listings (Cont.)

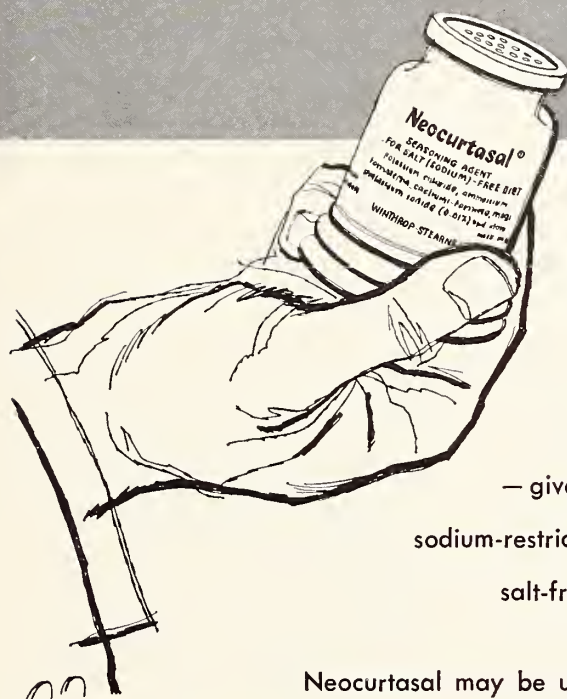
Name and Address of Physician	Type of Practice Desired
Charles E. Townsend, M.D. The Buffalo General Hospital Buffalo, New York	Internal Medicine (associate or assistant)
Edward S. Talaga, M.D. Illinois Research Hospital 1850 West Polk Street Chicago 12, Illinois	Obstetrics-gynecology
Louis E. Harrington, M.D. 3415th Medical Group Lowry Air Base Denver, Colorado	General practice
Dale W. Hayhurst, M.D. 1321 Baxter Street Pueblo, Colorado	General practice
Michael Murphy, M.D. Green Building Cadillac, Michigan	General practice and surgery
Don N. Orelup, M.D. 1508½ Hayden Amarillo, Texas	General practice
Robert Liggett Eastman, M.D. 419 Pearl Street Denver, Colorado	General practice (clinic)
Robert G. App, M.D. Saginaw General Hospital Saginaw, Michigan	General practice
D. H. Cramblett, M.D. 414 North Burgess Avenue Holdenville, Oklahoma	General practice
James H. Kelleher, M.D. 57 Jackson Street Lawrence, Massachusetts	Urology
William F. Ruoff, M.D. Milwaukee County Hospital Milwaukee, Wisconsin	General practice
Eugene M. Monroe, M.D. 5800 Stoney Island Chicago, Illinois	General practice
Capt. M. J. Everett, MC. 45 Ft. Benning Road Columbus, Georgia	Surgery
John R. Chamberlin, Jr., M.D. N.A.S. Barbers Point c/o Dispensary Oahu, T. H.	General practice

(Continued on Page 842)

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1. Heller, E. M.: The Treatment of Essential Hypertension. *Canad. Med. Assn. Jour.*, 61:293, Sept., 1949.

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I.S.M.A. Placement Service Listings (Cont.)

Name and Address of Physician	Type of Practice Desired
Capt. Henry M. Hanson, MC. 479th Medical Group George AFB, California	General practice
Capt. G. Schnieder, MC. Base Hospital W.A.F.B. Roswell, New Mexico	General practice (wants location for 3 M.D.'s)
Ernest C. Lydecker, M.D. 6 Roberts Street Butler, New Jersey	Internal medicine (wants location for 2 M.D.'s)
Charles A. Bonsett, M.D. 1433 North Pennsylvania St., No. 605 Indianapolis, Indiana	
R. C. McDonough, M.D. 515 Tulsa Norman, Oklahoma	General practice (group)
Charles Dalton, M.D. City Hospital of Akron Akron, Ohio	
James W. Sampsel, M.D. University Hospitals Cleveland, Ohio	Surgery
Gilbert Bogen, M.D. 7531 South Essex Chicago, Illinois	General practice
E. N. Rush, M.D. Buechel, Kentucky	General practice (would like 2 year locum tenems)
Robert E. Williams, M.D. 313 El Paso Avenue Norfolk 5, Virginia	General practice
Jordon L. Daniels, M.D. 8831 South Harper Chicago, Illinois	Surgery
Garfield Miller, M.D. City of Detroit Receiving Hospital Detroit, Michigan	General practice
John F. O'Brien, M.D. 9437 South Sacramento Evergreen Park, Illinois	General practice
George M. Wolverton, M.D. 3902 Caroline Street Indianapolis, Indiana	General practice and surgery
Reuben Rubisoff, M.D. 1234 Albion Chicago, Illinois	Surgery

(Continued on Page 844)

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Name and Address of Physician	Type of Practice Desired
Ray E. Thompson, Jr., M.D. 1951 Irving Park Road Chicago 13, Illinois	General practice
Malcolm Wrege, M.D. 3805 North Delaware Street Indianapolis, Indiana	Surgery
J. W. Johnson, M.D. Box 513 Ridge Farm, Illinois	
William R. Rose, M.D. 215 8th Street Waukegan, Illinois	General practice (Negro)
Samuel G. Welborn, M.D. 15 East Second Avenue Lexington, North Carolina	Urology (clinic)
Joseph M. Gist, M.D. 1681 Pinehurst St. Paul 5, Minnesota	General practice
H. A. Shafi, M.D. Miami Valley Hospital Dayton 9, Ohio	
Lt. Warren McClure, MC 130th Station Hospital A.P.O. 403, c/o Postmaster New York, New York	General practice
Joseph Azzouni, M.D. 2626 South Kingshighway Blvd. St. Louis 9, Missouri	Pediatrics
Capt. William D. Ritchie, MC Box 158 Schertz, Texas	
Carl M. Ebersole, M.D. Wadsworth VA Hospital Los Angeles 25, California	General practice
Alan Kulich, M.D. 3838 West End Avenue Chicago 24, Illinois	General practice
C. L. Ralcheff, M.D. Children's Hospital St. Louis, Missouri	General practice
Lt. Col. Voris F. McFall, MC USAF Hospital Norton Air Base San Bernardino, California	Surgery
Michael O. Monar, M.D. 249 Hoss Road Indianapolis, Indiana	

(Continued on Page 846)



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*Glass, S. J., and Rosenblum, G.: J. Clin. Endocrinol.
3:95 (Feb.) 1943.

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I.S.M.A. Placement Service Listings (Cont.)

Name and Address of Physician	Type of Practice Desired
Arthur E. De Nio, M.D. 215 Olive Street Denver, Colorado	Orthopedic
Marvin S. Cashion, M.D. P. O. Box 3788 San Juan 18, Puerto Rico	Surgery
Thomas K. Roberts, M.D. 1111 Cedar Street Michigan City, Indiana	
C. P. LeRoyer, Jr., M.D. 8 Endicott Street Beverly, Massachusetts	Internal medicine and pulmonary diseases
Joseph K. Collins, M.D. "Brookside Farm" R. R. No. 2 Knightstown, Indiana	General practice

Community Seeking Doctor	County	Population	Contact
Fowler	Benton	2,500	Hawkins & Rayle, Attys.
Twelve Mile	Cass	210	Ora Grable, President Lions Club
Mulberry	Clinton	800	James A. Weaver, Banker
English	Crawford	757	Roy Ewbank, County Agent
Ashley	DeKalb	794	Harold Swank, Funeral Director
Birdseye	Dubois	349	L. B. McKinney, Loan Company
Ferdinand	Dubois	1,251	H. G. Backer, M.D.
Nappanee	Elkhart	3,400	R. A. Fleetwood, M.D.
Matthews	Grant	518	Rene Marchal, Insurance
Carmel	Hamilton	1,500	Charles A. Gustafson, Insurance
McCordsville	Hancock	350	Dr. Fred Bratten, Veterinarian
Shirley	Henry-Hancock	1,152	B. F. Witt, Citizens State Bank
Russiaville	Howard	1,050	Leon Vandiver, State Bank
Red Key	Jay	1,732	John Teegarden, C. of C.
Wheatland	Knox	800	L. E. Carnahan, Postal Employee
Claypool	Kosciusko	452	Walter Bouse, Postal Employee
Silver Lake	Kosciusko	772	E. G. Summe, Hardware merchant
Syracuse	Kosciusko	1,500	Drs. Clark or Craig
Culver	Marshall	1,600	R. L. Witham, M.D.
Linden	Montgomery	592	Leon Little, Banker
Paragon	Morgan	600	Lulu Knoy, Bank manager
Kentland	Newton	1,860	George Sammons, Attorney
Cromwell	Noble	399	F. W. Messer, M.D., Kendallville
LaOtto	Noble	500	F. W. Messer, M.D., Kendallville

(Continued on Page 848)

Gastroenterological Association to Convene

The Eighteenth Annual Convention and Scientific Sessions of the National Gastroenterological Association will be held in the Biltmore Hotel, Los Angeles, October 12-14. The program will include symposia on cirrhosis of the liver, peptic ulcer, diseases of the large bowel and latest development in cancer research.

Following the convention the association's Fifth Annual Course in Postgraduate Gastroenterology will be given in the Biltmore Hotel and the College of Medical Evangelists. The course will be under the personal direction of Drs. Owen H. Wangenstein, Minneapolis, and I. Snapper, Chicago.

The Scientific Sessions are open to all physicians without charge. Further information on the Postgraduate Course will be furnished by the Executive Officer, National Gastroenterological Association, 1819 Broadway, New York 23, New York.

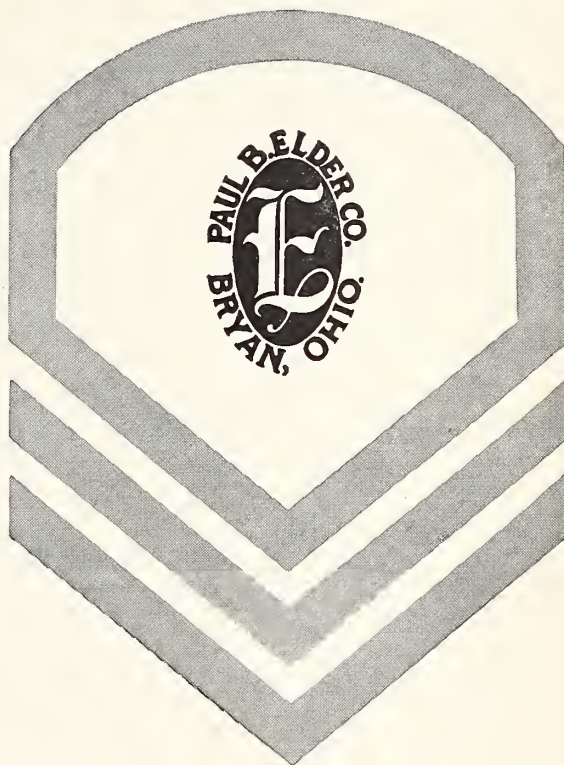


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Mount Vernon	Posey	6,150	L. R. Agin, C. of C.
Wadesville	Posey	350	Homer Wenderoth, Banker
Waldron	Shelby	600	Floyd Wagoner, Elevator manager
Rockport	Spencer	2,663	Laird Schoenfeld, Druggist
Hymera	Sullivan	1,200	R. P. Barnett, Auto dealer
Clarks Hill	Tippecanoe	503	J. C. Loveless, Postmaster
Liberty	Union	2,300	Leonard Roberts, Farmer
Cayuga	Vermillion	1,275	R. E. Watson, Funeral Director
Boonville	Warrick	5,592	D. W. Loomis, M.D.
Chandler	Warrick	1,500	O. C. Perigo, PK plant foreman
Idaville	White	500	C. H. Ogle, Postal employee

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4 years	\$ 4.00
3 years	3.25
1 year	1.50

AMERICAN MEDICAL ASSOCIATION
535 North Dearborn · Chicago 10, Illinois

INDIANA STATE BOARD OF HEALTH
Division of Communicable Disease Control
Polio Bulletin—August 8, 1953

County	Cases to Date	County	Cases to Date
Allen	9	Lawrence	1
Bartholomew	3	Madison	2
Blackford	3	Marion	18
Brown	1	Marshall	1
Clark	1	Monroe	1
Clay	2	Montgomery	4
Dearborn	2	Noble	3
DeKalb	4	Owen	1
Delaware	8	Perry	4
Elkhart	9	Porter	3
Franklin	1	Posey	1
Fulton	1	St. Joseph	9
Gibson	4	Scott	1
Grant	2	Spencer	2
Hamilton	1	Starke	1
Harrison	4	Steuben	1
Hendricks	5	Tipton	1
Howard	2	Vanderburgh	34
Huntington	2	Vermillion	1
Jennings	1	Vigo	6
Johnson	3	Wabash	3
Kosciusko	1	Warrick	1
LaGrange	1	Wayne	5
Lake	17	Wells	2
LaPorte	3		
		TOTAL	196

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CASES REPORTED TO DATE BY TYPE

Type	Number of Cases
Abortive	4
Non-paralytic	65
*Paralytic	87
Unspecified	40
TOTAL	196
*Spinal—21; Bulbar—23; Unspecified—43	

CASES REPORTED TO DATE, 1953 AND FOR CORRESPONDING PERIODS FOUR PRECEDING YEARS

Year	Number of Cases
1953	196
1952	180
1951	79
1950	84
1949	494

DEATHS

Nine deaths reported to date. One for Clay County, one for Decatur County with onset in 1952; one for Delaware County, one for Lake County, three for Marion County and two for Vanderburgh County.

Opinions From Here and There

Prepared for your information by the Committee on Public Policy and Legislation of the Indiana State Medical Association

BOSTON PHYSICIAN NAMED SPECIAL ASSISTANT TO MRS. HOBBY.

Doctor Chester Scott Keefer of Boston was appointed and confirmed as special assistant to Secretary of new HEW, Oveta Culp Hobby, with scant notice being given to this development of climactic importance to organized medicine. Acceptance of the post by a man of Dr. Keefer's stature puts another feather in the Administration's cap as a successful recruiter of top people to fill top posts.

DOCTOR KEEFER WELL QUALIFIED FOR POST. Chester Scott Keefer, M.D., is a prominent Boston physician. Professor of medicine at Boston University School of Medicine, Dr. Keefer received his medical degree from Johns Hopkins University in 1922. In addition to a long career in teaching, the new Special Assistant is an expert on antibiotics, supervising penicillin and streptomycin distribution for the U.S. and Allies in World War II. He was chairman of the National Research Council's Committee on Chemotherapeutics which advised on civil defense medical stockpiling. Dr. Keefer has been physician-in-chief at Massachusetts Memorial Hospital since 1940. He is a fellow of the American College of Physicians, a member of the American Society of Clinical Investigation and has served on the American Medical Association's Council on Pharmacy and Chemistry. Under terms of Reorganization Plan No. 1, creating the department, the Special Assistant is charged with reviewing and advising the Secretary on all health and medical programs of the department as well as on health and medical legislation.

SOCIAL SECURITY HEARING TO RESUME NOVEMBER 2. Completing two days of preliminary hearings on possible social security revisions, the House Ways and Means subcommittee headed by Rep. Carl T. Curtis adjourned until November 2. From statements of subcommittee members and questioning of witnesses, it is obvious that the group intends to re-examine fully the fundamental conditions on which the social security law is based.

OFFICIALS OF THE BUREAU OF CENSUS AND INTERNAL REVENUE testified that (1) future population trends cannot be accurately predicted

because of reversal of long-term trend in the birth rate; (2) present tax laws are inequitable, giving some ten million employed persons definite tax advantages over self-employed. The Subcommittee developed the fact there had been significant miscalculations in projected census figures used in the original estimates for the social security law. Example: 1934 estimates of actuaries placed the 1950 population at about 141 million; actual total for 1950 was 151 million.

INDIANA MAN MAKING FACTUAL STUDY FOR CURTIS COMMITTEE.

Howard Friend, statistical expert of the Indiana State Chamber of Commerce, has been loaned to Rep. Curtis's committee by the State Chamber for the purpose of analyzing the whole social security structure.

NEW HOOVER COMMISSION ON GOVERNMENT REORGANIZATION

begins work with former President Hoover as its chairman. The commission is starting work on a broad reorganization study of the Executive Branch of Government. The new commission takes up where the old commission left off and has until May 31, 1955 to make its report to Congress.

KOREA TRUCE NOT EXPECTED TO CHANGE CALL-UP OF PHYSICIANS

according to Defense officials who emphasize the Korean truce won't change plans for call-up of physicians under the doctor draft. The office of Army Surgeon General had this to say: "In view of the uncertainties involved during this initial period of truce, the Surgeon General cannot plan any immediate reduction of the number of physicians in Korea. However a careful study is being made in reference to filling future requests from the Far East for doctors. This office does not contemplate cancelling any orders already issued for duty in the Far East.

NATIONAL ADVISORY COMMITTEE IN ITS MOST RECENT

recommendation says that for the next 12 months "it is highly desirable" that calls for Priority III doctors be limited to those under 30 years of age. The committee adds "If deferments are not granted in this group, there probably will be a sufficient number available to fill the calls this fiscal year."

HILL-BURTON PROGRAM RECEIVES \$65 MILLION FOR THIS YEAR

ending a long standing controversy and indecision on this matter. The final figure is \$15 million more than the House voted and \$10 million less than the Senate approved total.

FIVE INSTITUTES OF HEALTH WON INCREASES

above House totals. The division and the final budget figures follow: Mental Health Institute, \$12,095,000; Heart Institute, \$15,168,000; Cancer Institute, \$20,237,000; Neurology and Blindness, \$4,500,000; Arthritis and Metabolic, \$7,000,000; Tuberculosis control, \$6,000,000; Hospitals and Medical Care, \$33,100,000.

ADMINISTRATION OFFERS COMPROMISE FOR BRICKER resolution in the form of an amendment to SJRes. 1, introduced by Sen. Knowland (R-Calif.) on July 22. Text of the amendment follows:

"Section 1. A provision of a treaty or other international agreement which conflicts with the Constitution shall not be of any force or effect. The judicial power of the United States shall extend to all cases, in law or equity, in which it is claimed that the conflict described in this amendment is present.

"Sec. 2. When the Senate consents to the ratification of a treaty the vote shall be determined by yeas and nays, and the names of the persons voting for and against shall be entered on the Journal of the Senate.

"Sec. 3. When the Senate so provides in its consent to ratification, a treaty shall become effective as internal law in the United States only through the enactment of appropriate legislation by the Congress.

"Sec. 4. This article shall be inoperative unless it shall have been ratified as an amendment to the Constitution by the legislatures of three-fourths of the several states within seven years from the date of its submission."

NEW SENATE PROCEDURE IN CALLING UP TREATIES. To prevent any treaty or constitutional amendment from passing the Senate with only a few members on the floor, the leadership has decided that such matters be considered only upon a quorum call and a yea-and-nay vote. Acting Majority Leader William Knowland told the Senate: "I believe that it is sound policy and procedure. . . . We shall endeavor to follow that policy as standard operating procedure from now on." The following day the Senate used the system for the first time in approving treaties of commerce and friendship with a number of countries. In five of the treaties (with Israel, Japan, Denmark, Greece, and West Germany), the Senate wrote in reservations that would protect states having laws against aliens practicing medicine and other professions.

Meanwhile, it appears likely that the Bricker Resolution will carry over to the next session of Congress. This is the proposed constitutional amendment by Senator John Bricker and 63 other Senators that seeks to limit the treaty-making powers of the Executive and to prevent treaties from superceding domestic laws. The Senate Republican Policy Committee met July 21 for three hours on the subject and discussed a compromise proposal offered by Senator Knowland. No agreement was reached and Senator Knowland indicated that it may go over to the next session. Senator Bricker said he was confident that grass roots sentiment by then would be stronger than ever.

HEPATITIS ON INCREASE: A sharp increase in infectious hepatitis is reported the first six months of this year compared with the same period in

1952, and a sharp decrease in measles. In the same period a significant decrease was noted in malaria among civilians, and a decrease of almost 90% among military personnel. About 25% more acute poliomyelitis cases were reported. The compilation was announced by National Office of Vital Statistics.

MINOR HEALTH MEASURES MOVE AHEAD AT CAPITOL with a surprisingly large number of bills with medical and health implications being moved through the Congressional mill.

SUBSIDIZATION OF VOLUNTARY HEALTH PLANS by the government as proposed by the Republican bill will definitely get underway with public hearings during the early part of next year, according to a statement credited to Rep. Robert Hale (R-Maine) chairman of the Interstate Subcommittee on Health legislation.

GOVERNMENT'S LATEST CONSUMER PRICE INDEX discloses that there has been a 0.3 per cent increase in the cost of medical care.

OMINOUS SILENCE OF SUPPORTERS, both in and out of Congress, of compulsory health insurance is regarded as a deep breather preparatory to a fresh assault in 1954, particularly if trends indicate overturn of Republican control in House and Senate.

3 YEAR TB PRESUMPTION, HR 5636 was unanimously passed by the House. A veterans' aid bill, it amends existing law so that presumption of service-connection is extended to include all types of tuberculosis occurring within three years following discharge from military duty. At present, only pulmonary tuberculosis is so covered.

ADOPTION OF "CHLORTETRACYCLINE" as generic term in Federal Food and Drug nomenclature in lieu of "aureomycin" was passed by Senate and sent to the White House to pave way for registration of former title by Lederle.

NARCOTIC DRUG CONTROL INTENDED TO STRENGTHEN Federal control over the synthetically produced habit-forming drugs, making them subject to same regulations as narcotics derived from opium and other natural sources, seemed nearer when the House and Senate passed HR 5561.

ANOTHER MOVED INTO TARGET AREA with the placing of the job held by Wilbur J. Cohen in the new department of HEW in schedule "C", the policy making bracket outside the protection of Civil Service. Cohen has long been a target of organized medicine because of his views on national health insurance. We can expect to hear of his leaving his post most any time now.

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THE DIAGNOSIS OF PULMONARY EMBOLI

RICHARD N. KENT, M.D.*

Fort Wayne

THE DIAGNOSIS of pulmonary emboli is stated in some texts as usually not being difficult, but my experience does not bear this out. The decision as to whether or not pulmonary emboli account for the condition of the patient when seen has, more often than not, been a difficult one to make. With the advent in recent years of effective measures in the treatment of pulmonary embolism, the decision is an important one to make. The old treatment of "masterly inactivity" no longer holds.

Of prime importance in making the diagnosis of pulmonary emboli is awareness of the problem and the consideration of it as a possibility. Reviews of autopsied cases in which pulmonary emboli were the principal cause of death frequently state that in retrospect a large proportion of the cases had premonitory signs and symptoms for a sufficiently long period of time to have allowed adequate therapy to be instituted.^{1, 2} A knowledge of the life history of a pulmonary embolus is therefore of help in looking for and evaluating these premonitory signs and symptoms. Allen, Barker and Hines³

state that it is probably best to consider pulmonary embolism as a part of rather than as a complication of thrombophlebitis.

The following concept of the life history of thrombophlebitis and of embolism is quoted from the book on Peripheral Vascular Disease by Allen, Barker and Hines as I do not know of any more concise and clear explanation of this phenomenon. Pulmonary embolism may be seen in association with the primary or local types of thrombophlebitis but more commonly it occurs in association with the secondary types in which group are included post-partum, post-traumatic, and post-operative thrombophlebitis and thrombophlebitis complicating infectious diseases, blood dyscrasias and such non-infectious systemic diseases as carcinoma and heart disease particularly when there is congestive failure. In these conditions, it is a common clinical observation, that non-fatal pulmonary embolism may precede the clinical appearance of thrombophlebitis by one to three days, occasionally one to two weeks. Actually, when thrombophlebitis and embolism occur in the same case, the first clinical episode is most frequently the embolism. There is considerable clinical and pathologic evidence for the following concept of the pathogenesis of throm-

* Doctor Kent, a specialist in internal medicine, presented the above paper at the 1952 Annual Convention of the Indiana State Medical Association.

bophlebitis and embolism. Venous thrombosis (phlebothrombosis) usually occurs in episodes of which there may be one or several. If the thrombus develops in a small vein, part or all of it may be detached soon after its formation to become a small or non-fatal embolus. If it is not detached or if only part of it is detached, the clinical signs and symptoms of thrombophlebitis will develop and will indicate the involved vein. A second episode may occur in which the thrombus propagates into a larger, more proximal vein, and this episode may be characterized by detachment of this new thrombus to form a larger or fatal embolus, by the development of clinical signs and symptoms of thrombophlebitis in this vein or by a detachment of a small non-fatal embolus from part of the thrombus and development of signs and symptoms of thrombophlebitis at the site of the remainder of the thrombus. If the first episode of thrombosis occurs in a larger vein, such as the iliofemoral, the first and only sign of its occurrence may be sudden fatal pulmonary embolism. If the thrombus remains in situ, the clinical signs and symptoms of iliofemoral thrombophlebitis develop. A small fragment of the thrombus may be detached to form an embolus and the rest may remain to produce clinical iliofemoral thrombophlebitis. Thrombosis may occur in the veins of both lower extremities simultaneously or episodes of thrombosis may develop first in one leg and then in the other or in veins in other parts of the body. At the onset of any episode of thrombosis, embolism may occur. However, after a venous thrombosis has existed in situ for three or four days, at the most, and has produced clinical signs and symptoms of thrombophlebitis, this thrombus does not detach to form an embolus.

The reasons for this concept are as follows: All evidence points toward the fact that marginal organization of a thrombus takes place rapidly, usually within the first 24, certainly within the first 48 hours, and this organization is accompanied by rather firm adherence of the thrombus to the wall of the vein. The histologic examination of fatal pulmonary emboli fails to reveal any evidence of organization; therefore, it must be assumed that these emboli are detached thrombi or fragments of thrombi of recent origin.

The problem then is to diagnose the small, non-fatal pulmonary emboli as they serve to warn that subsequent more serious pulmonary emboli may very likely occur if measures are not taken to prevent them. What points then in the patient's history and physical examination are there which would alert one to entertain the possibility and probability of thrombophlebitis and of pulmonary emboli?

The history of the case will bring out the situations in which thrombophlebitis or phlebothrombosis is likely to occur. These situations were previously mentioned in the discussion of the life history of thrombophlebitis and of embolism. The symptoms most commonly associated with pulmonary emboli are: chest pain, either pleuritic or anginal in type, dyspnea, tachycardia, fever, hemoptysis and vascular collapse.

The diagnosis is made by tying together the background of the patient, the symptoms and the physical and laboratory findings. In addition to this, I believe that one of the most valuable aids in making the diagnosis of pulmonary emboli is a high degree of suspicion that the condition may be present and account for the situation in which the patient is found. The possibility of the condition must be kept in mind when one is called to see a patient whose medical or surgical convalescence is not progressing satisfactorily.

Review of the patient's chart will frequently show that there has been a gradual rise of temperature and pulse rate for several days. Review of the nurse's notes may show a single memorandum to the effect that a day or two before, the patient mentioned that he had a pain in the lower chest on one side or the other on deep breathing or coughing. The pain was probably not severe enough or persistent enough to cause the patient to call it to the attention of his physician on his visit that day. I believe that a review of the patient's chart in detail and an organization of events chronologically in the physician's mind is essential.

The patient's condition on examination may vary widely. The patient may not appear acutely ill although he is usually aware that something untoward has taken place. On the other hand, there may be severe chest pain. There may be great apprehension, and the patient may be psychotic. There may be shock and vascular

collapse. Hemoptysis may be a prominent symptom. The patient's condition may be so precarious that physical examination can be undertaken only with a good deal of difficulty.

The absence of striking or positive physical findings in regard to the chest or peripheral veins should not deter one from making a diagnosis of pulmonary emboli or considering it strongly if the other features of the case are suggestive. There are no pathognomonic physical signs on examination of the chest but one or a combination of the following are important aids: (1) Rales which are apt to be limited to a relatively small area; they are likely to be fine, moist and inspiratory in type. (2) A pleural friction rub. (3) Accentuation of the second pulmonic sound and a systolic murmur at the second left intercostal space adjacent to the sternum.

Cyanosis, particularly with a small embolus, is not usually prominent. The pulse rate is moderately elevated. The temperature may be only slightly or moderately elevated. With a small embolus, the blood pressure is usually not appreciably affected.

X-ray examination of the chest may be of very little help in the case of a small pulmonary embolus as there may be no abnormal roentgenographic findings. Positive, suggestive X-ray findings are: a wedge shaped shadow of increased density in one of the lung fields, elevation of the diaphragm on the affected side, increased hilar markings on the affected side, enlargement of the pulmonary conus and increased prominence of the right side of the heart, pleural thickening and occasionally a small amount of fluid in the costophrenic sinus. Healing results in linear scarring visible by X-ray and considered diagnostic by some. Two practical difficulties arise in the use of X-ray examination of the chest. One that is often encountered is the absence of a recent pre-operative or pre-embolic chest X-ray upon which a comparison of positive findings may be made; in this instance, positive findings may be confusing. Another is that the patient's condition is so serious that it is felt that only a bedside plate can be made, and the patient's condition may prevent him from cooperating fully; the abnormal findings under these circumstances may also be confusing. The absence of abnormal X-ray findings in the chest does not rule out the

possibility of a pulmonary embolus. A chest X-ray, however, should be made because of its possible aid in differential diagnosis.

The electrocardiogram⁴ may be an aid in suggesting the diagnosis of pulmonary embolism or confirming pulmonary embolism in suspected cases. The changes have been described. The pattern is that of acute cor pulmonale. It is characterized by right axis deviation with a prominent S wave in lead I, a depressed S-T segment in lead II and often in lead I, a Q wave and an inverted T wave in lead III and a diphasic or inverted T wave in lead IV F. An upward convexity of the S-T segment in lead III is common; and elevation of the S-T take-off in this lead occurs in a few cases. The changes in the electrocardiogram are not always present in pulmonary embolism. They may develop at any time during the first 48 hours after the embolism occurs, and they may be transient, but when they are found, they are significant.

In conclusion, the diagnosis of pulmonary emboli is not always easy. Of utmost importance, and I believe the single most important factor in making the diagnosis of pulmonary embolism, is to be on the alert for the premonitory symptoms and to keep the possibility of the occurrence of pulmonary embolism in mind in following the patient's convalescence.

If this is done, appropriate therapy may be instituted in time to be effective, and there will be fewer instances when, at postmortem, it is said, "In retrospect, this diagnosis could have been made sooner."

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SPONTANEOUS HEMOPNEUMOTHORAX

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SPONTANEOUS hemopneumothorax is an intriguing and controversial disorder. It still remains a very uncommon entity, with obscure etiology. The disorder is controversial—for its proper treatment was, and still is a disputable subject.

The purpose of this paper is to summarize two additional cases and to re-evaluate accepted methods of treatment.

CASE REPORTS

Case No. 1: H. N., a 26 year old married tavern keeper, was admitted to the hospital on 3-22-50. His chief complaints were pain in the right side of the chest and shortness of breath. He reported that he was well until 3-20-50, when he awoke with a feeling of pressure in the right chest. He soon felt the urge to cough, suddenly developed a very sharp pain in the right anterior chest accompanied by marked dyspnea and profuse perspiration. The patient had no chills or fever and the coughing did not recur. The pain became aggravated during the next 48 hours and the dyspnea increased.

The systemic review was essentially normal. There was no history of respiratory infection, or injury, previous to onset of symptoms. The past history revealed a similar but less severe episode of chest pain in 1949.

Physical examination showed a temperature of 98.0°, pulse of 120, respirations 36, and blood pressure 105/60. He was a well developed, undernourished man who appeared acutely ill. There was marked general pallor, with cyanosis

of the lips and nail beds. The trachea was markedly deviated to the left. The interspaces of the right chest were bulging, and there was generalized hyperresonance over the right lung field except for flatness at the right base, posteriorly. Breath sounds over the entire right lung field were absent. The cardiac dullness was displaced to the left and the apical thrust was felt in the sixth left interspace in the mid-axillary line.

Laboratory data included an essentially normal urine analysis, negative blood Mazzini. The hemogram revealed a hemoglobin of 80%, a red blood count of 4,400,000 per cu. mm., a total leucocyte count of 12,850, with 80% neutrophils and 17% lymphocytes. A sagittal x-ray of the chest on the day of admission showed complete collapse of the right lung with a shift of the trachea, mediastinal structures and heart into the left chest. Definite "effusion" was seen at the right base. The opinion of the roentgenologist was that the patient had a tension pneumothorax with pleural effusion (figure 1). Meanwhile the patient became markedly orthopneic with clinical signs of moderate cardiac embarrassment. The patient was prepared for thoracentesis and decompressed slowly. The chest fluid was grossly bloody but did not clot on standing. The laboratory reported negative smears for both routine and acid-fast organisms.

The patient improved immediately after thoracentesis on 3-22-50. A repeat chest film (figure 2) on 3-27-50 showed that the pleural fluid had increased in quantity and complete collapse persisted. Thoracentesis was repeated on 3-29-50 and 530 cc. of dark sanguinous fluid were removed. The fluid again failed to clot. Another chest x-ray on 4-3-50 (four days later) revealed the pleural fluid had increased further (figure

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3). During this time, the first and second strength Mantoux tests gave negative results. Meanwhile the patient had shown continuous clinical improvement since the original thoracentesis and was asymptomatic when dismissed on 4-8-50.

A chest film taken several weeks later showed that the involved lung had completely re-expanded. The pleural effusion had disappeared and there were no apparent adhesions (figure 4).

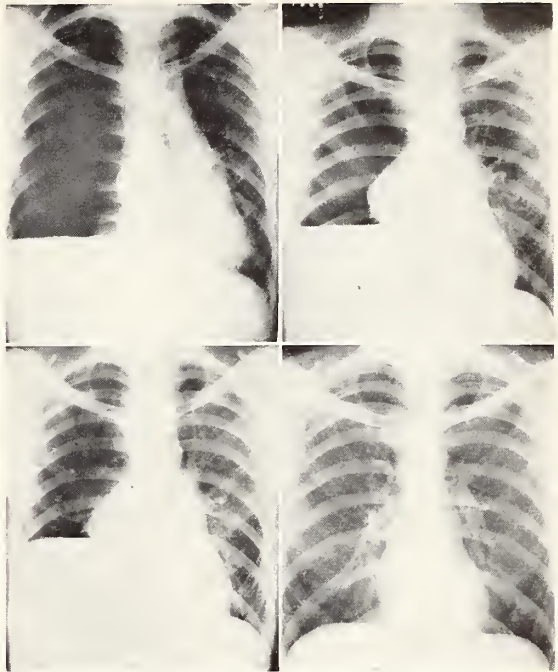
Case No. 2: D. J., a 22 year old university student, was admitted to the hospital on 10-19-50. His chief complaints were severe chest pain with shortness of breath. The patient stated he had felt well until two days previously, when, at rest, he had a sudden pain in the right chest, posteriorly. The pain was very sharp and was accompanied by dyspnea. During the next 48 hours there was gradual increase in pain with persistent shortness of breath.

The systemic review showed that the patient had been suffering from an upper respiratory infection with sore throat and cough for two days previous to onset of his symptoms. The past history was noncontributory.

Physical examination revealed a temperature of 99.2°, pulse 112, respirations 26, and blood pressure 100/60. The patient appeared anxious and complained of right-sided chest pain. There was marked pallor and moderate cyanosis. The trachea was not displaced, but there was splinting of the right hemithorax. All the intercostal spaces on the right were distended. There was generalized hyperresonance over the right lung field with complete absence of breath sounds and fremitus. The cardiac dullness was not displaced to the left. The rhythm was regular and the tones were of good quality.

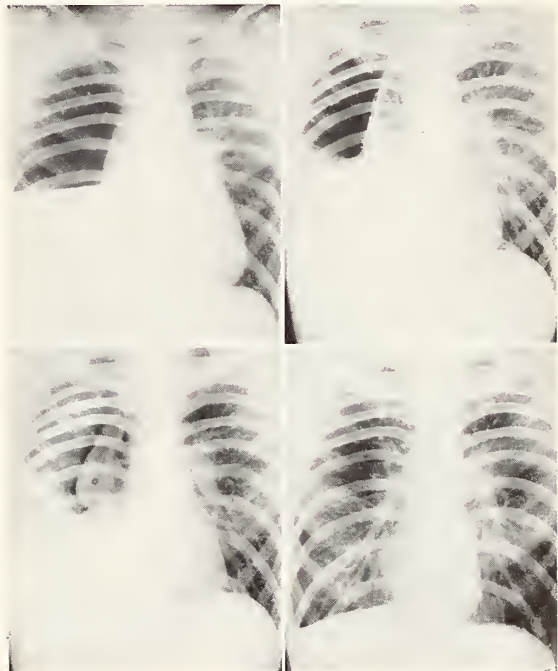
Laboratory examination showed an essentially normal urine analysis. The blood Mazzini was negative. A complete blood count revealed a hemoglobin of 40%, a red blood count of 2,780,000 per cu. mm., a white blood count of 17,500, with 77% neutrophils and 22% lymphocytes. A chest film on 10-20-50 showed complete collapse of the right lung with a fluid level extending up to the level of the fourth anterior rib. There was no shift of the mediastinum (figure 5).

A thoracentesis was done on 10-20-50 and 1440 cc. of grossly bloody fluid were removed.



Figs. 1 through 4, above, show progressive changes in patient (Case 1) with spontaneous hemopneumothorax. History outlined in text.

Below, reading from left to right, are chest films of Case No. 2, described in accompanying text.



The laboratory report showed this fluid had a hemoglobin content of 86%, a red blood cell count of 4,730,000 per cu. mm. Smears for routine and acid-fast organisms were negative. The patient was given 500 cc. of blood by trans-

fusion on 10-20-50 and 10-23-50. He was given 300,000 units penicillin daily. Both first and second strength Mantoux tests were negative. A second x-ray of the chest on 10-27-50 showed slight expansion of the upper and middle lobes; however the fluid was essentially at the same level (figure 6). Thoracentesis was repeated on 10-28-50 when 1840 cc. of grossly bloody fluid were obtained. The fluid did not clot but showed a hemoglobin of 76% with red blood cell count of 3,710,000 per. cu. mm. During this procedure, the patient complained of severe pain in the right anterior chest with a constant urge to cough. He developed marked pallor, and the skin became cold and moist. A low grade fever ensued and the chest pain persisted for 24 hours.

On 11-3-50 a survey film of the chest showed that the fluid level was essentially the same (figure 7). The patient's temperature became normal on 11-4-50, 16 days after admission. A chest film taken several weeks after dismissal revealed radiologic signs of pleural adhesions (figure 8). Even so, he remained asymptomatic.

Discussion

Ever since Pitt's¹ and Rolleston's² original reports in 1900, approximately 64 cases of spontaneous hemopneumothorax have been reported. The etiology of the syndrome has never been definitely established. Frey³ classified the condition as "spontaneous" only when there were no definite causes present, such as underlying lung disease or trauma. Several authors, e.g. Birch⁴, Houdsen and Piggot⁵, attributed the condition to torn pleuro-visceral adhesions. Hopkins⁶, and Matson⁷ reported that these adhesions were probably supplied by intercostal vessels which were of sufficient size to produce massive hemorrhage. Hartzell⁸, Fisher⁹, and Hayashi¹⁰, studied its pathogenesis and arrived at the conclusion that the disorder was due to rupture of thin walled pleural vesicles probably the result of healed tuberculosis or a manifestation of localized emphysema. Kirshner¹¹ thought that these "bullae" were a result of congenital pleural defects.

In spontaneous hemopneumothorax, the physical findings and symptoms usually are identical with those of spontaneous pneumothorax. Typically there is a history of sudden onset of pain, generally while the patient is at rest. The pain is usually knife-like, but may be dull. Usually

there is immediate dyspnea and orthopnea, but these latter findings may not become manifest to a serious degree until there is accumulation of fluid in the chest. A rapidly developing "effusion" following pneumothorax may be due to accumulation of blood. If the hemorrhage is massive, shock and collapse may ensue. Louria¹² and Hopkins⁶ observed the presence of abdominal pain and rigidity which they attributed to irritation of the diaphragm, with spasm of the recti muscles.

Cosgriff's¹³ recent studies of the coagulation mechanism of pleural blood in hemopneumothorax explain the deficient clotting qualities of blood in the pleural cavities. He found that the fluid was completely devoid of prothrombin, thrombin and fibrinogen. There was, however, no anticoagulant activity found in the pleural blood.

Most authors have believed that thoracentesis usually is not indicated, but Sellors¹⁴ advocates aspiration of the blood because fibrin deposited over the lung may act as a constricting barrier preventing expansion and encouraging fibrosis.

That hemopneumothorax remains a medical emergency is shown by the studies of Helwig¹⁵ who reviewed the literature in 1947 and reported findings in 14 patients who had come to autopsy. At that time there had been approximately 60 cases reported. Arst, Lahey and Kunkel¹⁶ more recently reported an overall mortality of 30%.

Comment

In both of our cases it was observed that there was increased pleural effusion (bleeding) after the second thoracentesis. In the first case there was symptomatic improvement only after the initial thoracentesis. Recovery was uncomplicated. In the second case also, the chest was aspirated on two occasions, but the patient developed signs of shock after the second thoracentesis. Increased hemothorax followed. An x-ray taken several weeks after dismissal revealed that numerous pleural adhesions had developed, but the patient was symptom-free.

The question arises as to why the blood in the pleural cavity of the first patient was completely reabsorbed without sequelae, while the second patient developed pleural adhesions. A plausible explanation could be that, in certain cases of spontaneous hemopneumothorax, large

quantities of thromboplastic substance are discharged from damaged pulmonary tissue into the pleural spaces. Such an event could explain the low prothrombin and fibrin content of the aspirated sanguinous fluid, as well as the tendency to pleural adhesion formation. Conceivably, certain cases may be attended by such *large* accumulations of thromboplastin that fibrothorax would be the result. Repeated thoracenteses, in such cases, might not materially alter the ultimate outcome.

This is not a categorical plea to treat cases of spontaneous hemopneumothorax without aspiration. However, it remains evident from the first case that, aside from the mere presence of blood in the pleural space, there is at least one other factor responsible for the formation of pleural adhesions. If this factor is quantitatively related to the concentration of thromboplastic substance in the chest cavity, such concentration would probably not be affected by therapeutic thoracentesis. Post-traumatic hemothorax, by the same token, would be expected to be followed by a higher percentage and degree of pleural adhesion formation.

Summary

Two cases of spontaneous hemopneumothorax are presented. In one case, there was complete recovery following thoracentesis to relieve tension pneumothorax. In the other case, thoracenteses were followed by secondary intrapleural hemorrhage, shock, and formation of pleural adhesions. Some concepts are presented to explain the rationale of therapy in various phases of the disorder. Tension pneumothorax is the only absolute therapeutic indication for thoracentesis in spontaneous hemopneumothorax.

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MODERN SCIENTIFIC AUDIOLOGY

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AUDIOLOGY is a recently developed specialty which deals with the problems of evaluating and retraining the communicative habits of persons having permanent hearing impairments. Audiology as a profession received great impetus during World War II when the medical departments of the armed forces recognized the necessity of rehabilitating large groups of hearing-handicapped individuals. Over 13,000 service men and women¹ were treated at the Army and Navy Aural Rehabilitation units. These centers coordinated the skills of members of the medical profession, mainly otologists and psychiatrists, and of non-medical professions, such as speech therapists, teachers of the deaf, psychologists, electrical engineers, and social service workers. After the war, work with veterans and military personnel was continued at such rehabilitation centers as the Navy Rehabilitation Center in Philadelphia, the Army Audiology and Speech Correction Center at Walter Reed Hospital, and the Veterans Audiology Center in New York City.

Similar services have been made available to civilians. A number of hospitals have organized audiology centers, many of them using personnel who helped develop the military units. Some of the hospital units are associated with medical schools, such as those at the State University of Iowa, Indiana University, Northwestern University, the University of Illinois, Washington University, the University of Pittsburgh, and Johns Hopkins University. A number of colleges and universities have also organized audiology units as part of their speech and hearing clinics. At present over 40 are listed in the Directory of Hearing Rehabilitation Facilities in the United States². In addition to offering services to the audiologists for work in medical audiology units and with the hard of hearing elsewhere.

Modern scientific audiology is progressing into some very definite patterns. The essential facilities include carefully planned, acoustically treated rooms, various types of pure-tone and speech-reception audiometers, devices to simulate a variety of daily-noise environments, individual and group electronic hearing trainers, a library of reputable hearing aids, facilities for making the ear impressions necessary for ear molds, properly trained scientific resident staff members, and qualified medical, psychological, and sociological staff consultants. To demonstrate the coordination of such team effort in the designated physical facilities, a description of the audiological program at Purdue University is here presented.

Seeks Medical Advice

The audiological services at Purdue University, organized with medical consultation, are under the supervision of Dr. M. D. Steer, Director of the Clinic, Dr. George Shaffer, long interested in hearing problems and a specialist in lipreading, audiometry, and auditory training, and Miss Frances Patton, who has worked with hearing problems at the Navy's medical aural-rehabilitation center, at the University of Illinois, and at Purdue University. This group is advised by local medical consultants and is assisted by four non-medical staff members who have had training and experience in handling hearing measurement and by a staff of electronic engineers who design, construct, and maintain the equipment. The entire staff conducts a considerable amount of research in the efficacy of current evaluational and retraining techniques, modifications in test procedures, the design of new methods and tests, and the development of new electronic equipment.

This clinic makes it possible for any Purdue University student to obtain complete audiological services. It has also been possible to

* Purdue Speech and Hearing Clinic, Purdue University, West Lafayette, Indiana.

make most of these services available to other residents of the State of Indiana. Among the services offered to the public are comprehensive testing for the assessment of residual hearing, complete hearing-aid evaluations, and as much auditory training as possible.

Clients from outside the University come from many sources. A number are referred by otologists; some are sent by agencies such as the Indiana State Vocational Rehabilitation Division and the Indiana Society for Crippled Children; some are referred by school authorities, including the superintendent, the speech therapist, the school nurse, and the traveling Purdue Hearing Test Service; others learn of the Clinic through their friends or from directories of such services. During the past year the age range of clients was from 2 to 91.

Written evidence of an otological examination within the preceding three months is required before an appointment can be made for a hearing-aid evaluation, and this requirement is never waived. It is necessary to make sure that a hearing aid is never substituted for medical treatment and that, except in unusual cases, an aid is not recommended unless the loss is permanent. The Clinic furnishes the client's own physician with a brief diagnostic blank, which may be returned directly to the Clinic. This blank is designed to elicit information that should be taken into consideration in determining whether or not amplification is desirable, particularly if there is any condition which contraindicates the use of amplification. Information is also requested about any condition, such as active or recurrent otitis media, which may necessitate the use of a bone conduction aid. After the testing has been completed, a report of the test results and recommendations is sent to the examining otologist.

Must Have Appointment

A complete hearing-aid evaluation for an adult requires at least two visits to the Clinic. Since each visit takes from one to three hours, an appointment is mandatory. During the first visit an assessment of the loss is made and an impression for an ear insert is taken if necessary. On the second visit comparative tests are made with various appropriately chosen hearing aids. Only aids approved by the Committee of Consultants on Audiometers and Hearing Aids of

the Council on Physical Medicine of the American Medical Association are included.

The evaluation of residual hearing consists of a subjective self-report, pure-tone audiometry, and speech-reception testing. The case history interview includes information about such factors as duration of the loss, the amount of difficulty encountered in typical situations, the communication ability required by the client's profession or job, his previous experience with amplification, as well as a report of tinnitus, recruitment, diplacusis, and tolerance. During this part of the interview the clinician gathers an impression of the degree of the client's disability and of his attitude towards his loss and the use of an aid and discovers whether or not his speech has been affected.

Equipment Most Modern

The conventional air and bone conduction audiometric pure-tone tests are given in a sound-proofed room. The Clinic has five audiometers available for use. Since these include the latest models, it is possible to give any of the conventional pure-tone tests, recruitment tests, and loudness-balance tests and to use masking when needed.

In order to do the intensive audiological testing required for further assessment of the communication handicap, a considerable amount of newly developed electronic equipment is necessary. High-fidelity equipment of this sort is expensive to obtain, is large in terms of space requirement, necessitates the use of sound-proofed rooms, and requires skilled engineers to maintain its operational accuracy. The equipment used in speech-reception testing at Purdue University is located in two sound-proofed air-conditioned rooms. The tester, in the control room, can present live voice or signals from a phonograph, a tape recorder, an audio-oscillator, or a noise generator. If live voice is used, the intensity of the signal can be monitored through the use of a VU meter, which is inserted at the output of the preamplifier. Another meter, measuring the intensity of the electrical input to the loud speaker, gives an instantaneous check on the calibration of the equipment. An attenuator controls the output intensity of the signals at any level from 0 to 110 decibels. While the client sits in the test room at a measured distance from the loudspeaker, responses are noted by the

tester over a "talk-back" system. In addition to this binaural free-field testing, monaural measurements are made with ANB-H-1 receivers. All this equipment is checked regularly, and the calibration and freedom from distortion are maintained by a staff of electronic engineers.

The speech-reception threshold (threshold of intelligibility)³ is compared with the normal speech-reception level, predetermined by testing in this particular set-up. This threshold is the level at which the client can understand and correctly repeat half the standardized speech material presented to him. The hearing loss for speech can thus be measured as the number of additional decibels required by the impaired ear to hear an equivalent number of words. The test to measure this function, developed by Hudgins and his associates at the Psycho-Acoustic Laboratory at Harvard University⁴, consists of dissyllabic words of the spondee stress pattern.

A hearing aid gives optimum benefit when the loss, according to this measurement, ranges between 40 and 75 decibels, though many people need and make good use of amplification with a 30-to 40-decibel loss. When the loss is at the other end of the scale, over 80 decibels, a hearing aid may not always give complete understanding of speech, but it usually gives enough help to constitute a good foundation for a course in auditory training and lipreading and may in this way aid in attaining adequate communication ability.

While this measure of sensitivity is important, the discrimination ability is perhaps of even greater clinical significance. The client who says, "I can hear, but I can't understand," presents a familiar problem. Egan and his associates⁵ at the Psycho-Acoustic Laboratory designed a series of tests to measure this ability to distinguish one sound from another when both are audible. The tests consist of 20 phonetically balanced lists of 50 words each, with any one test giving a measure of the discrimination ability. Unless the tolerance problem is too great, this measurement is made at a level 30 to 35 decibels above the client's threshold.

A high discrimination score is usually found when the medical diagnosis is that of a conductive-type impairment.^{6, 7, 8} Prediction of satisfactory hearing-aid use can generally be made in these cases if all other factors are favorable.

A low discrimination score, on the other hand, will ordinarily be found when the impairment is predominantly perceptive. These cases present a greater problem in rehabilitation. The selection of a suitable hearing aid becomes a much more vital factor for these individuals, and they need considerable guidance in learning to use amplification. The person with mixed-type deafness combines the attributes of these two groups in varying degrees and his communication problems must be assessed on an individual basis.

The result of speech-reception testing cannot be predicted by studying a pure-tone audiogram, but must be measured directly, though correlations between the two types of tests are known.^{8, 9} When wide discrepancies persist during retests and under further special testing, the client is referred back to his otologist.

Ears Compared

The discrimination test is administered monaurally when a comparison between ears is desired, and it is also given with a measured noise background. Tolerance is checked with short sentences at increased intensity until discomfort is reported.

If the results of the examination indicate that a hearing aid is advisable, an impression is taken for an ear insert and arrangements are made for a return visit. The importance of an individually fitted ear-piece for the trial and subsequent use of a hearing aid is well accepted.¹⁰ It may be noted that an air-conduction instrument should be used whenever possible because of the greater amplitude and fidelity of the output. Bone conduction is indicated only when suppurative otitis media exists or when there is an extremely low tolerance threshold for loud sounds. The latter condition can be determined, however, only in the test situation.

When the client returns for the actual evaluation of hearing aids, the ear mold is carefully checked and about a half dozen suitable aids are tried. The aids used in any given evaluation are chosen for their appropriateness to the individual's loss. The data concerning performance characteristics of the instruments as furnished by the manufacturers are used as a guide. The hearing-aid library at Purdue University, which contains instruments on consignment, accepts only approved aids. The aids are tried in-

formally for general acceptability to the client and are then checked by giving the free-field speech-reception tests described above. A threshold is obtained, the discrimination ability is measured in quiet and in noise, tolerance is checked, and the usable range is noted. If the original setting of an instrument is not satisfactory, other suitable settings are tried before the aid is eliminated. Care is taken to set the volume controls of the hearing aids at equivalent levels based on a sample of speech at a measured intensity. A maximum volume setting is also tried to check the reserve of the instrument.

These tests yield comparative data on the amount of communication assistance received by this individual. They also give a check on whether or not the preferred aid meets the basic requirements outlined by the Office of Scientific Research and Development.¹¹ These are (1) *sufficient power* to override the patient's loss and make sounds audible; (2) *tolerability*—audibility, and intelligibility without pain, tickle, or discomfort; (3) *fidelity*—the amplification of normal speech without distortion, so far as these factors may be properties of the aid; (4) *wearability*—the earpiece, or headband, and instrument must not give undue discomfort; and (5) *sufficient sensitivity and amplification* to render ordinary speech at the conversational level intelligible within the limits of the loss. Other factors, such as wide dynamic range of speech input, pleasant quality for listening to speech and music, low internal noise, esthetic qualities of the instrument itself, availability of the aid and service, and items of individual preference, are taken into consideration and given various weights. Some of these factors are checked outside the sound-proof rooms in normal and noisy environments.

A recommendation is then made on the basis of all information obtained during the test situation: from the case history, the tests of residual hearing, the comparative tests of hearing-aid efficiency, and subjective observation of the client's reactions. The client is given full information about the preferred aid, and as much time as possible is spent on auditory training. For clients from outside the University, this training at the present time is made up mainly of instruction in the care and use of the aid and of advice on rebuilding listening habits and developing a healthy attitude towards the handi-

cap. The staff recognizes the vital role of auditory training in helping these people to attain the maximum efficiency possible in communication situations.

Children's Tests Modified

The problems involved and the methods employed in assessing a child's residual hearing are much more complex and even more time consuming. Some of the basic equipment is the same, but the methods of obtaining similar measurements are modified according to individual needs. It is sometimes necessary to give a very young child a course of training before any decisions can be reached. However, quite reliable estimates of the hearing of children as young as two and three years of age have been made. This necessitates, of course, the expenditure of a great deal of time and the exercise of considerable care and caution in interpreting results.

The hearing rehabilitation services available to all residents of the State of Indiana have been described. It is, however, possible to give a student of Purdue University all the other services of an audiology clinic. An extensive course in lipreading is given to all hard-of-hearing students. Since speech and voice therapy are usually needed, this training is a definite part of the program. The Clinic also gives individual work in auditory training, including a personal evaluation of the disability, training in interpretation of minimal cues, conditioning to amplified sound, instruction in the use of an aid in various situations, and consideration of social and vocational problems. Medical treatment is available and psychiatric referrals can be made. Through cooperation with other campus departments, vocational guidance and psychological assistance are available. In other words, the University student may obtain all the benefits of an audiology program extended over a longer period of time than was available even to military personnel during the war, and this help may be obtained while living a normal college life.

A hearing loss carries with it social, educational, and psychological implications. It is the aim of a modern scientific audiology clinic to help minimize the handicapping aspects of these factors by restoring the optimum amount of communication ability whenever medical or

surgical measures cannot fully restore the hearing function.

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INTERMITTENT LEFT BUNDLE BRANCH BLOCK

Report of a Case

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ALTHOUGH intermittent transitory bundle branch block is not a rare condition, complete left bundle branch block, which can be replaced by normal conduction at any time, is an unusual clinical oddity.

Case Presentation

History:

L. T., a 46 year old lieutenant colonel, was admitted to the hospital on January 14, 1952. In October, 1951, an EKG taken as part of an annual officers' physical examination revealed the characteristic pattern of left bundle branch block in all leads (Fig. 1). Subsequent electrocardiograms consistently demonstrated this abnormality. The patient, therefore, was admitted to the hospital for a period of observation and study. He had no complaints and was enjoying his usual good health.

Past History:

In 1947, this officer was hospitalized for five days because of sudden epigastric pain, associated with a cold sweat. A diagnosis of "stomach spasm" was made. No electrocardiogram was taken. Annual physical examination in 1948, including electrocardiogram (Fig. 1) was normal. However, again in 1949, he had another episode of epigastric pain, requiring hypodermic medication for relief. He was returned to duty after a few days of hospitalization. A third episode, for which the patient did not seek medical attention, occurred a few months prior to the present hospital admission.

* Captain Chappel, who presented this paper before the Section on Medicine at the 1952 Annual Convention of Indiana State Medical Association, is now in private practice in Franklin.

† Colonel Watson is now stationed in Germany.

Physical Examination:

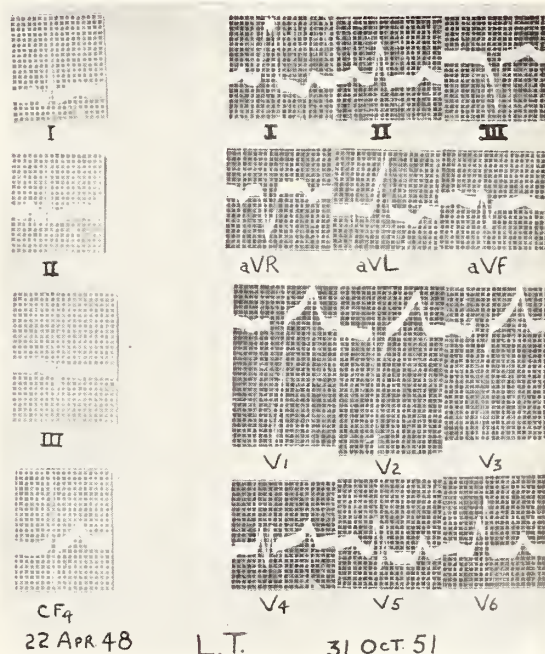
Well-developed, well-nourished, white male in no acute distress. Head and neck normal. EENT, normal. Lungs clear to percussion and auscultation. Blood pressure, 130/80. Heart not enlarged. Regular rhythm; 78 per minute. No murmurs. Liver, kidneys and spleen not palpable. Genitalia and rectal, normal. Reflexes, physiological. Extremities, normal.

Laboratory Data:

Serology, negative. Sedimentation rate, 4 mm/hr. Urinalysis: specific gravity, 1.018; 1-3 WBC's per high power field; albumin and sugar,

Figure 1. Left: EKG of 22 April 1948 taken during routine physical examination showing normal intra-ventricular conduction.

Right: EKG of 31 October 1951 taken during routine physical examination showing characteristic left bundle branch block in all leads.



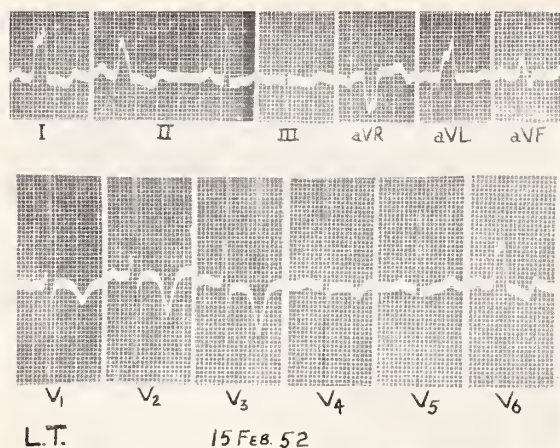


Figure 2. EKG of 15 February 1952 showing bundle branch block in some leads and normal conduction in others. Note transition from bundle branch block to normal conduction within period of one beat in Lead II and T wave inversion V1-V4.

negative. Stools for ova and parasites, negative. WBC, 7,850; neutrophils, 50%; lymphocytes, 43%; eosinophiles, 2%; bands, 5%; hematocrit, 48%. Chest x-ray, normal. Cardiac fluoroscopy normal. Gall bladder x-ray, normal. G. I. Series, normal. Barium enema, normal. Spine x-ray, normal.

Electrocardiograms:

Serial EKG's continued to show left bundle branch block until February 15, 1952 (Fig. 2). At that time, normal conduction appeared in Lead 3 and V1-5. In one lead there was complete conversion from bundle branch block to normal conduction within one beat. On February 18, 1952, the intraventricular conduction was normal in all leads (Fig. 3). However, T wave inversion was present in V1-4. Since this represented a reversal of T wave pattern from April 22, 1948, it was concluded that there might have been myocardial damage in the interim and that the prolonged intraventricular conduction probably was due to definite anatomical changes in the bundle. However, since normal conduction was present on some occasions, the anatomical changes more than likely were not sufficient to produce complete loss of conductivity and, therefore, the presence or absence of bundle branch block might be due to other metabolic and physiological factors.

In an attempt to determine these factors, several studies were made. From frequent observations, the following facts were noted:

- (1) Except for short infrequent episodes of

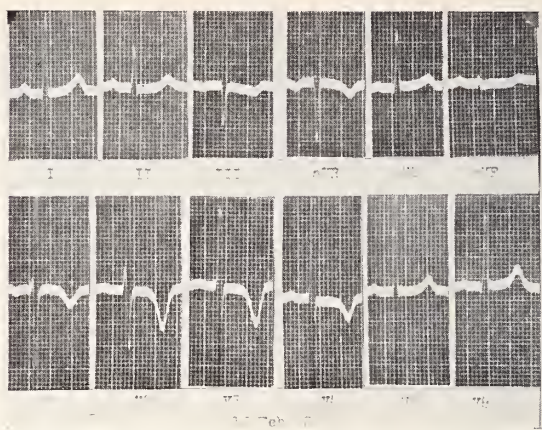


Figure 3. EKG taken 18 February 1952 showing normal intraventricular conduction in all leads and T wave inversion V1-4.

spontaneous bundle branch block, a continuous strip of Lead I, taken with the patient lying down, showed normal conduction.

(2) A continuous strip of Lead I, taken with the patient sitting up, consistently revealed the presence of bundle branch block without episodes of normal conduction. With these observations as controls, further studies were made to discover what would produce the block with the patient lying down and what would abolish the block with the patient sitting up.

Bundle branch block could be produced at any time within several seconds and maintained as long as desired by having the patient talk of unpleasant or emotionally upsetting subjects, such as promotions, politics, commanding officers, heart disease, etc. Normal conduction would return when conversation turned to more pleasant topics. Smoking a cigar after abstinence from tobacco for 48 hours also produced more frequent and sustained episodes of bundle branch block.

The bundle branch block present with the patient sitting could be converted temporarily to normal conduction at any time by one of the following:

- (1) lying down
- (2) left or right carotid sinus pressure (Fig. 4 E, F)
- (3) Valsalva maneuver (Fig. 4 D)
- (4) binocular pressure

Although partial atropinization with large doses of tincture of belladonna over several days

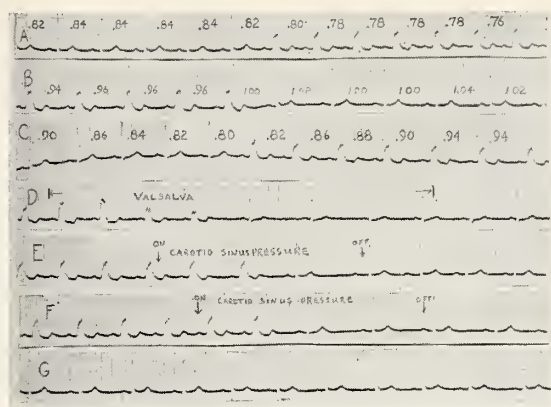


Figure 4. (RR interval measured in seconds)

A. Spontaneous appearance of bundle branch block with increase in rate as measured by RR interval.

B. Spontaneous disappearance of bundle branch block with decrease in rate as measured by RR interval. Rate during bundle branch block here is slower than during normal conduction in A.

C. Spontaneous appearance of bundle branch block with decrease in rate as measured by RR interval.

D. Effect of Valsalva maneuver.

E. Effect of carotid sinus pressure.

F. Effect of carotid sinus pressure.

G. Difference in size of complexes frequently noted spontaneously without relation to rate, respiration or bundle branch block.

did not produce definite symptoms, such as dryness of the mouth or blurring of vision, a continuous strip of Lead I taken while sitting up on the fifth day, showed only occasional episodes of bundle branch block. After a few days without tincture of belladonna, bundle branch block was again consistently present in Lead I taken with the patient sitting. This would seem to indicate that atropine aided in abolishing the block. Inhalation of 100% oxygen for several minutes and sublingual nitroglycerin 1/100 gr. on two occasions had no effect on the prolonged intraventricular conduction.

Discussion

Various reasons have been offered to explain the phenomenon of transitory and intermittent bundle branch block. Vesell^{6,9} and others² suggest that there is a critical rate at which the appearance or disappearance of bundle branch block can be brought about by very slight alterations in rate. The temporary failure of conduction in these instances is thought to be due to local functional changes in the bundle branch which are the result of fatigue. This theory was disputed by Sandberg, et al¹¹ and Canter⁷, who could find no such critical rate in their cases.

We, also, were unable to demonstrate a critical rate. In one instance where conduction changed from normal to bundle branch block spontaneously, the rate was actually slower during the presence of block (Fig. 4C). No rate at which bundle branch block would invariably appear was discovered (Fig. 4A, B).

The influence of change of position on the conductivity was noted by Sandberg et al¹¹. Our patient almost invariably had bundle branch block while sitting up. Change of position from reclining to sitting or standing produced bundle branch block; conversely the bundle branch block present while sitting or standing would usually disappear when the patient again lay down. This change in conduction usually occurred within a few beats and without transition forms. Since change in position itself seemed to produce bundle branch block in this case, the effect of exercise could not be properly evaluated.

The effect of tobacco and emotion on bundle branch block has not been reported previously. The effect of tobacco on people with and without heart disease has been investigated⁴. It is known that frequent auricular and ventricular premature contractions may be produced by excessive use of tobacco⁵. Our patient was accustomed to smoking 10-15 cigars per day. Smoking after abstinence from tobacco for 48 hours seemed to produce more frequent transitory episodes of bundle branch block than previously noted. Strong emotions, such as anger, fear and apprehension also seemed to produce runs of bundle branch block with greater frequency than seen during a control period. The exact mechanism through which these factors operate in this case is not clear. Comeau et al² and Bohnengel³ have stated that if the time of conduction through a damaged bundle is only slightly faster than through the septum, there are certain metabolic and physiologic changes, such as fatigue and recovery time of conduction fibers, nutrition, and oxygenation which influence the presence or absence of bundle branch block. Thus, tachycardia¹² tends to produce bundle branch block, and oxygen and coronary vasodilators^{1,2} tend to alleviate bundle branch block. One of Comeau's cases had bundle branch block only when having anginal attacks. We could demonstrate no effect of coronary vasodilators or of oxygen on the bundle branch block.

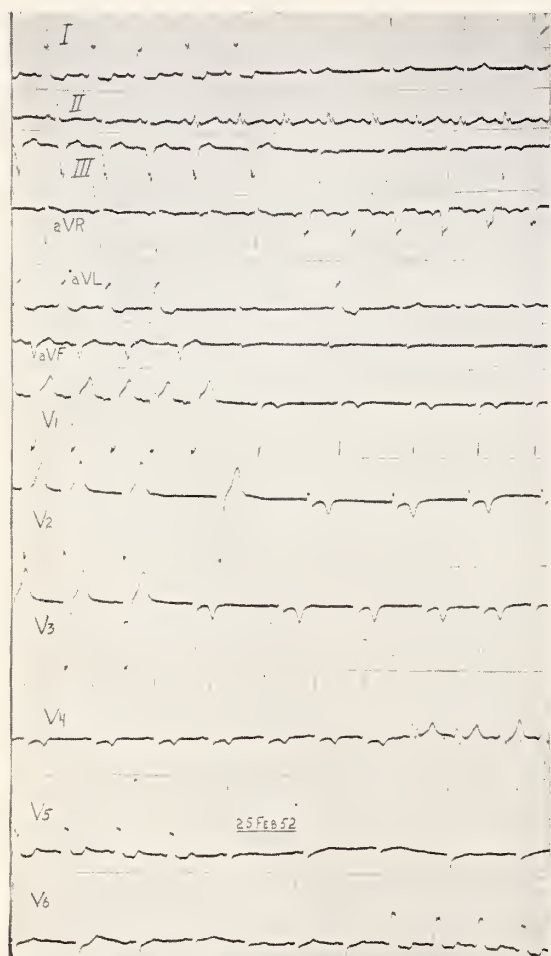


Figure 5. Complete EKG taken 25 February 1952. Normal conduction produced in some leads by carotid sinus pressure. Spontaneous re-appearance of bundle branch block in the other leads. Note one complex of bundle branch block between two normal complexes in aVL. Also note the aberrant complexes at the end of Lead V4.

The exact mechanism by which vagal tone affects intraventricular conduction in transitory and intermittent bundle branch block is not definitely known. Yater¹ concludes that in the presence of partial lesions of one or both branches without complete interruption of function release of vagal tone induces bundle branch block by increasing the heart rate. The consensus of opinion^{1, 2, 10, 11} is that vagal stimulation exerts its effect by slowing the heart rate. Nichols⁸ found that atropine initially produced transitory normal conduction, but subsequently caused bundle branch block to re-appear. He feels that vagal stimulation may have a direct effect on the intraventricular conduction system since vagal stimulation in his case caused disappearance of bundle branch block without slowing

the heart rate. In our case, indirect vagal stimulation by carotid sinus pressure, binocular pressure or Valsalva maneuvers caused a disappearance of the bundle branch block and slowing of the rate. Paradoxically, however, after administration of atropine in the form of tincture of belladonna to suppress the vagus, bundle branch block was much less likely to replace normal conduction. When our patient sat up, under these circumstances, there were infrequent transitory episodes of bundle branch block. Most of the time, conduction was normal. A review of the literature reveals that both vagal stimulation and atropine have each been responsible for both producing and abolishing delayed IV conduction in susceptible individuals.^{1, 2, 8, 11} In our case, both vagal stimulation and atropine tended to produce normal conduction. It is evident that further clarification is needed as to the role of the vagus in bundle branch block.

Summary

1. An interesting case of intermittent left bundle branch block, which could be produced or abolished by several factors, is presented and illustrated.

2. The various factors are briefly discussed.

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EXPERIENCE IN MANAGEMENT OF PEPTIC ULCER*

ROBERT L. JOHNSTON, M.D.

Bluffton

I WILL DISCUSS briefly the physiology of gastric secretion as it applies to patients with peptic ulcer and follow with the presentation of a few cases treated with a relatively new pharmaceutical product, Kolantyl, which contains some old and familiar ingredients.

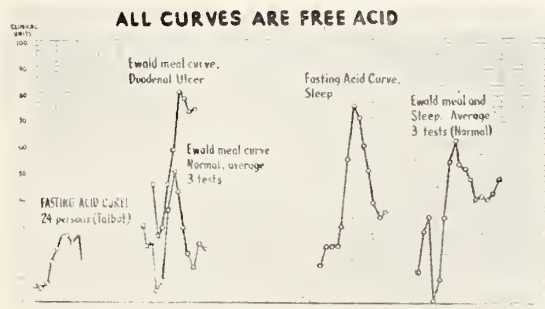


Fig. 1

The graph on the extreme left in Figure 1 represents a composite of the free acid of continuous secretion of 35 normal subjects, after Talbot.¹

The next, lower graph, to the right is a composite of three Ewald test meals on a normal subject given at the breakfast hour.² Just above this graph is a typical curve of a test meal on a patient with a duodenal ulcer.³ Note that in the ulcer patient the fasting acid is higher, increases more after the test meal and remains *up* longer.

The third graph on the right is the free acid

curve in sleep on the same normal subject just described in the second lower curve. Compare this also with the average of 35 subjects in the extreme left, or first graph. It shows that the free acid in a normal subject goes *higher* in sleep, even comparable to that of a patient with peptic ulcer tested while awake. Graphs on sleep and hypnosis, with stomach empty, are almost exactly alike.^{2, 3}

The curve on the extreme right is a composite of three Ewald meals given just before the subject retired.² Compare it with a composite of three tests on the same subject at breakfast time, (lower second graph on the left) and note that in sleep the test meal evokes a higher response of acid and that the acid remains high for a longer period.

Levin, Kirsner and Palmer⁴ have shown that on the average the normal subject secretes ap-

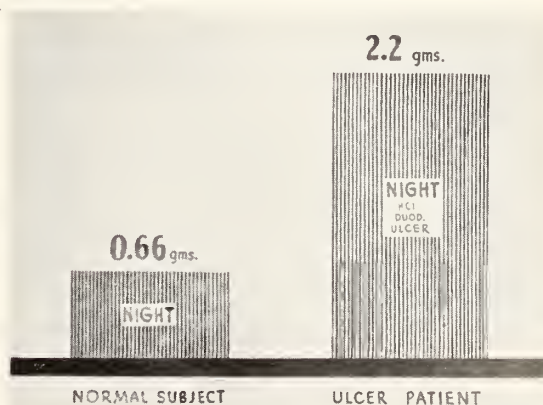


Fig. 2

* Paper presented at the 1952 Annual Convention of the Indiana State Medical Association.

proximately 0.66 grams of hydrochloric acid during the night. On the contrary, they find that the patient with duodenal ulcer secretes 2.242 grams of hydrochloric acid, or *more than three times as much*.

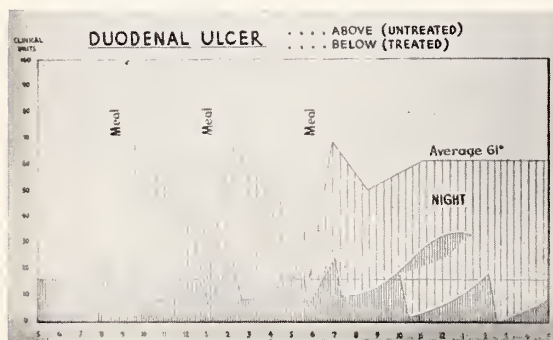


Fig. 3

Let us recall the duodenal ulcer graph of Figure 1, upper second curve, and set up a hypothetical day without treatment for a 24 hour period. Refer to Figure 3. The upper graphs here show about what happens with three meals a day, and an empty stomach at night. In treating this patient we hope to depress this acid curve into a low *therapy zone* of acidity as near zero acidity as possible. If we give the usual antacids an hour after meals and at bedtime we may hope to get a result like the lower graph, shaded area. There will be peaks of acidity before each meal and at night. Most likely the patient will eventually come to surgery because of inadequate acid control. *How* may we abolish these peaks and accomplish *adequate* control of acid? We must know something about this particular patient's acid production. If he is not given 13 feedings a day, as in the Sippy method, he should have at least six feedings a day with *enough* antacid an hour after each feeding. A good antispasmodic facilitates gastric emptying and helps relieve pain. Night therapy must be in terms of the acid produced. The bedtime dose may need to be 4 times the single day postprandial dose. In some cases the patient may need to be awakened for doses each 4 hours or he should take a good dose of antacid each time he awakens. In other words we must neutralize *almost* all of the acid all of the time and we must abolish all of the patient's pain in this way throughout the 24 hours.

Eases, Magee and Ivy, 1952,⁶ showed that bentyl hydrochloride given intravenously to dogs

in 12.5 mg. doses produced an effect comparable with that produced by 2.5 mg. of atropine sulphate in abolishing urocholine induced contraction of the choledocho-duodenal mechanism. They found that bentyl hydrochloride at a dose of 25 mg. relieved morphine induced contraction of the choledocho-duodenal mechanism to the same extent as 2.5 mg. of atropine sulphate.

McHardy and Browne, 1952,⁷ in a radiologic study on patients found no significant difference in the effect of bentyl hydrochloride, banthine and prantal on the relief of pylorospasm associated with pain, and found all three superior to atropine. When bentyl, banthine and prantal were given in equivalent amounts (100 mg.), banthine and prantal had a greater antispasmodic effect. However, bentyl did not cause cardiospasm as banthine sometimes does. They remark that the absence of significant side effects of bentyl permits its more general use.

When the patient is *instructed* and sent home, it is not enough to *tell* him what to do. We must *SELL* him on the idea and explain to him why. We must have proved to him by symptom control and by acid test that he is to control his *acid* and *pain* 24 hours a day. Control of pain may not mean control of acid. His initial prescriptions must contain adequate medication to do just this until he is seen again. Follow-up x-rays are important to show progress or failure in therapy.

If acidity is adequately controlled and there is still pain, either a complicating cause or a psychosomatic reason should be sought.

Gastroscopy is indicated in all cases of gastric ulcer, with gastroscopic follow-up if not operated. It is indicated in all cases of ulcer-like pain not explained adequately by the x-rays. It is necessary to confirm a diagnosis of gastritis. Esophagoscopy is done when peptic ulcer of the esophagus is suspected. Esophageal dilation is done for obstructing cardiospasm.

All cases with obstruction due to spasm or inflammation must have the stomach evacuated each night before receiving the large bedtime dose of antacid.

Those cases of duodenal ulcer who have scarring which results in a relatively high grade permanent obstruction to gastric emptying must of necessity have a gastric resection, and we prefer a high resection which removes three-fourths or more of the stomach and thereby greatly reduces acid production, and a posterior

Polya type gastrojejunostomy. In the aged, in poor condition, gastroenterostomy plus vagotomy would be the operation of choice.

Kolantyl in the Treatment of Peptic Ulcer

In view of the conflicting theories concerning the etiological factors involved in ulcer production and the mechanism which is responsible for "ulcer indigestion" and pain, it is evident that no single medicament would be generally accepted in its treatment.

Kolantyl*, a relatively new pharmaceutical product, was especially formulated to aid the physician in his 24 hour a day attack against all of the present day concepts of etiology in ulcer production, and to provide him with an effective weapon to counteract the conditions thought to be responsible for ulcer symptoms.

Each tablet of Kolantyl contains the following ingredients:

Bentyl hydrochloride†	5 mg.
Aluminum hydroxide gel	400 mg.
Magnesium oxide	200 mg.
Sodium lauryl sulfate	25 mg.
Methylcellulose	100 mg.

Bentyl hydrochloride is a relatively new selective antispasmodic of low toxicity and negligible side reactions found to be far superior to atropine sulphate in non-toxic doses of the latter. Doses of atropine of comparable action are usually not tolerated clinically. Items 2 and 3 are well known antacids which do not disturb the acid-base balance. Sodium lauryl sulphate has an antilysozyme action. Methylcellulose adds bulk and forms a gel to coat the ulcer and should in this way delay the exit of the antacid from the stomach and thus prolong its action.

A study was undertaken to determine the effectiveness of Kolantyl in treatment of peptic ulcer. Seventeen patients, all of whom showed radiological evidence of peptic ulcer, were included in this study.

Method. Ten of the patients were confined to bed during treatment and fed on a "Sippy" schedule and received one tablet of Kolantyl hourly on the half hour and four at 9:00 P.M.,

* Kolantyl is the trademark of the Wm. S. Merrell Company, Cincinnati 15, Ohio.

† Bentyl hydrochloride is the trademark of the Wm. S. Merrell Company, Cincinnati 15, Ohio, for its brand of dicyclomine hydrochloride (diethylaminocarbethoxy-dicyclohexyl hydrochloride).

or alternatively, were put on a modified Meulengracht diet with two tablets of Kolantyl at 8:00 A.M., 1:00, and 6:00 P.M. and four at 9:00 P.M. If gastric acidity was relatively high at the beginning of treatment, a capsule containing 10 mg. of bentyl hydrochloride and $\frac{1}{4}$ grain of phenobarbital was given three times daily. Any patient having gastric retention was aspirated completely before 10:00 P.M. and a night dose of Kolantyl, usually four tablets, given thereafter.

Results. In the majority of cases the patients were free of symptoms after the first day of treatment. All obtained early relief within the first week. Twelve patients showed radiological evidence of healing. Three others completely relieved of symptoms have not had follow-up x-rays. The remaining two cases showed x-ray evidence of improvement—a smaller crater and less duodenal spasm. Other patients with symptoms and x-ray evidence of duodenitis, without peptic ulcer, obtained satisfying relief on the same therapy.



Figure 4. On left, duodenal ulcer before treatment. On right, three weeks after treatment.

Figure 4, left, is a specimen x-ray of the stomach of patient H. P. showing an ulcer crater in the duodenum before treatment. The x-ray on the right shows the result of three weeks treatment.

Figure 5, A and B shows two x-rays of patient R.B., deformed cap, irregularity on lesser curvature diagnosed by radiologist as gastric ulcer. Operation refused. Treatment, as outlined, begun, ambulatory, with modified Meulengracht diet, etc. Lower left x-rays C and D show the status on July 14 and 28, 1951.

Enlarged area E, on the right, shows the status of the duodenal cap and involved lesser

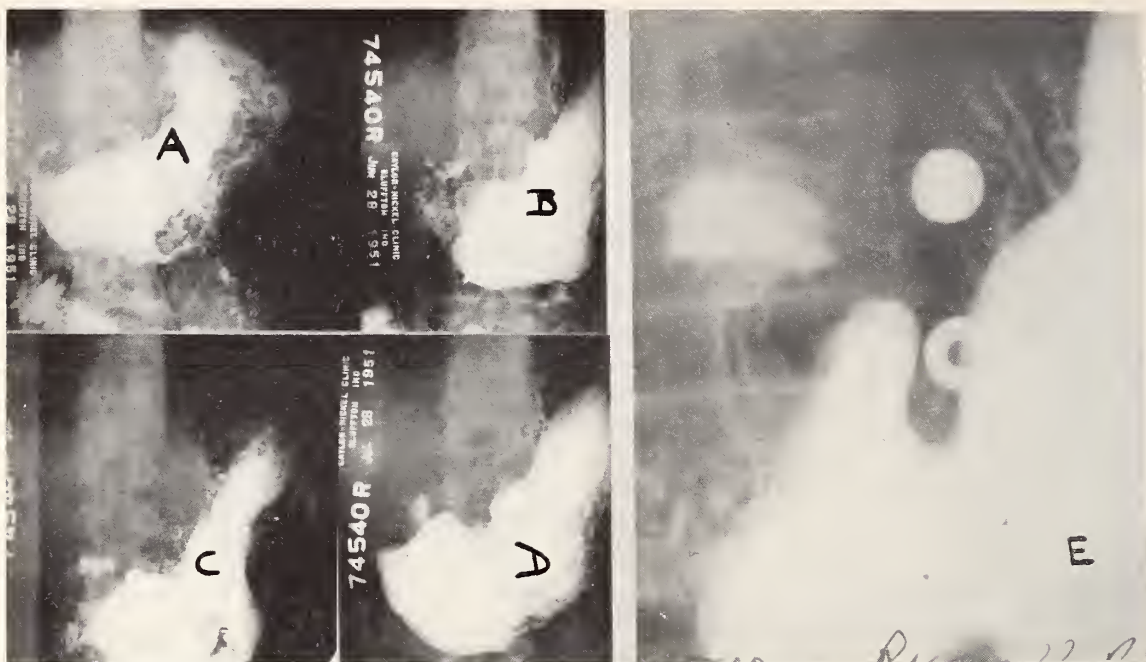


Figure 5. A and B, gastric ulcer, deformed antrum and cap before treatment; C and D, 16 and 30 days after treatment. E, two months after treatment.

curvature of the antrum on August 25, 1951. The patient has continued symptom free while on diet, and Kolantyl, while working. X-rays in September, 1952, show some irregularity of the lesser curvature in the same area. Gastroscopy then showed patchy hypertrophic gastritis in the region where an ulcer was previously described by x-ray.

Conclusions: Three cases of gastric ulcer and fourteen of duodenal ulcer were treated with the relatively new, combined formula containing the antispasmodic bentyll hydrochloride, the antacids aluminum hydroxide gel and magnesium oxide, and sodium lauryl sulfate. The preparation, Kolantyl, when combined with conventional methods of rest, diet, adequate day and night acid control, and psychotherapy when needed, has in our hands proved to be a very effective agent in the treatment of peptic ulcer.

Final Summary

1. Gastric juice volume and acidity increase in sleep.
2. Night acid production of the duodenal ulcer patient is more than three times that of the normal subject.
3. Ulcer patients need education on acid control 24 hours a day.
4. A good antacid preparation should not cause alkalosis, should be palatable, remain in the stomach well by reason of mass and ad-

hesiveness, should coat the ulcer and should not constipate.

5. A good antispasmodic should have a minimum of side reactions and should be sufficiently non-toxic to be tolerated in doses which accomplish its purpose.
6. Kolantyl has seemed to meet requirements of 4 and 5 in a relatively satisfactory manner.

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TESTIMONY BEFORE REFERENCE COMMITTEES

"The time and place of meetings of all reference committees shall be publicly posted, and all meetings of all reference committees shall be open to all members of the Association."

PARTICIPATION by members of the Indiana State Medical Association in the deliberations of its House of Delegates has always been encouraged, as witness the above quotation from the By-Laws.

During the Annual Convention at French Lick on October 19, 20 and 21, the program has been arranged to facilitate still further this democratic process.

The House of Delegates will hold its first meeting on Sunday, October 18, the day before the convention opens. Reference committee meetings are scheduled to begin at 9 a. m. on

October 19, and will continue, if necessary, during that afternoon.

All legislative and policy making bodies, when faced with a large mass of detailed work, accomplish their purposes through the medium of reference committees. Here it is that facts which bear upon the issues are obtained. Here it is that the opinions of many individuals are solicited and obtained. Testimony by individuals before these small and hard-working committees is one of the fine points of democratic government.

The Indiana State Medical Association is blessed with a House of Delegates which is made up of some of its most conscientious and diligent members. This year the Councilors are urging each member of the Association to attend, if possible, the meetings of the House, and to take an active interest in at least one of the reference committees. Each year many important matters are deliberated. Correct decisions may be reached with the help and participation of the entire membership.

AMERICAN MEDICAL EDUCATION FOUNDATION

THE ANNUAL REPORT of the AMEF for 1952 has just been received. A total of \$906,533.82 was contributed during the year by individuals and organizations. Since all the administrative expenses of the foundation are paid by the A.M.A. the entire amount is available for payment to the medical schools of the country.

Indiana may well be proud of its standing in this great campaign to save the medical schools of the nation from the withering effects of Federal subsidy. Indiana ranks first among the states in the number of individual contributors, 1217, and first in the amount of contribution, \$58,152.54.

The Indiana AMEF Campaign Committee is

stressing the importance of increasing the number of contributors. This is an undertaking in which all physicians are interested. It provides an opportunity to reimburse the medical school from which each doctor graduated for a part of the educational expense which we did not pay directly. If the campaign is successful it will literally save the nation's medical schools from Federal domination.

It is the hope of the committee and the Council that every member of the State Association will make a contribution in 1953. The size of the gift is not important. Everyone is urged to give according to his means. No gift is too small. All gifts are deductible for Federal income tax purposes.

CORRECTIONS . . . AND APOLOGIES

The Medical Yearbook of *THE JOURNAL* lists Eugene L. Hendershot, M.D., 118 Southeast First Street, Evansville 8, incorrectly. In both the alphabetical and the Vanderburgh county listing the surname is printed as "Henderson". The correct name is "Hendershot".

Wilbur W. Ross, M.D., has occupied the same offices at 904 Madison Street, LaPorte, for 33 years and is still at that address. An order to change mailing of *THE JOURNAL* to his postoffice box several years ago was interpreted as a change of address.

THE JOURNAL staff will appreciate information about any other incorrect listings in the Medical Yearbook roster of members.

President's Page

September, 1953

FELLOW MEMBERS OF I.S.M.A.:

PRESIDENT EISENHOWER is a staunch supporter of medical education under private and state control. He states, "Only if our medical schools remain financially solvent can we hope to place medical education on a sound basis, free from the threat of government-sponsored plans or schemes to control it." He thinks the \$10,000,000 campaign throughout industry and the medical profession is the only way to keep medical schools from relying upon the Federal government. We, the medical profession, desire to prevent subsidization of medical schools which could produce an environment where students could be indoctrinated into accepting the course of least resistance in living and working "forever and a day" on a government payroll.

The Indiana State Medical Association is to be complimented in being at the forefront in raising money in behalf of the American Medical Education Foundation. Well, Josh Billings said "The wheel that squeaks the loudest is the one that gets the grease." Over \$82,000 has been subscribed by Indiana physicians and Indiana's School of Medicine received \$37,000 in 1952. We trust you will continue to support Doctor Denny and his committee in adding to this amount in 1953. The National Foundation for Medical Education and the American Medical Education Foundation have raised and contributed well over \$3,000,000. These funds have made possible the securing of additional teachers, the purchase of teaching equipment, and the expansion of teaching facilities. The Medical Society of New Jersey recently presented the Foundation \$25,000. The Woman's Auxiliary to the A.M.A. contributed \$10,000 at our last convention. The A.M.A. has donated \$1,500,000 which should erupt praise from even its most vitriolic critics.

In making your next contribution and while pouring it from your cornucopia of plenty, take the opportunity to write your medical school some suggestions, destructive and constructive, on ways and means of improving medical education, during this period when the medical schools are endeavoring to "keep up with the Joneses". During the past twenty years, I have visited every medical school in the United States, except three, at least twice. In conversing with students, alumni, and some of the "holier than thou" faculty, a few of their comments are noted. In the first place, the professional relationships between medical schools and physicians are not too congenial. Steps should be taken to improve these relationships and to eliminate the undercover disquietude. Medical schools should adopt and enforce measures which will restrain their infringement upon their graduates in the private practice of medicine.

The Council on Medical Education in hospitals has been responsible for elevating the standards of medical schools. However, some think that standards are being made for the sake of standards, and that the accentuation of research has transcended the art and practice of medicine. In vying with one another on standards, medical school planners may be providing thought, but little

action, about the cost of medical education. They are overlooking the elimination of non-essential data and material from class-room work, and the substitution of material which the student might specifically employ in the early days of his medical practice. Of course, it is difficult for a Dean of a medical school to specify, for example, just what the professor of Physiology should teach, but one could hire another. Fifty percent of the teachers in our entire educational system fail to put their "stuff" across to the average student. Some think a few medical schools should confine themselves to research while the majority should be content to teach the research of others. This would establish a better ratio of research schools to those of practical every-day medicine, and certainly, it would permit department heads to teach instead of investigate. It has been suggested that in the interest of economy, pre-medical education might revert to the two-year requirement, and these two years might be spent to a better advantage in hospital training or in general practice. Other physicians are advocating that most graduates of medicine should spend several years in general practice before beginning a specialty. This plan would supply the nation with an ample number of general practitioners and decrease the number of specialists. Likewise, if more C-students were admitted to medical schools, the ratio of those who are qualified to teach to those who are not interested in pedagogy would increase the number of general practitioners.

But the dearth of general practitioners is not due entirely to curricular abnormalities, educational costs, unnecessary utopic standards and necessary specialty boards. Communities who desire physicians do not always make their locations attractive and when a physician does reside in a community, a community should consult him before highballing to a physician in a nearby medical center. Again, during recent years many medical students marry while in medical school and hospital residency, and although the doctor would gladly locate in a small community, his wife often refuses to live in a small town. The Rural Health Committee, chaired by Doctor Dudding, and in conjunction with our genial, overworked Mr. Waggener, is working on a brochure outlining the requirements of a community in soliciting a physician.

The shortage of physicians and nurses at present is in part due to the demands of the Armed Services. Unequal distribution of those at home is, in part, also responsible. It may be that respective states may need to set up revolving loan funds to finance prospective nurses and medical students. Those financed should be required to practice a specified time in their home state and in communities which need physicians and nurses. Repayment of each loan could be planned so as not to work hardship on anyone. Grants to students other than scholarships should not be countenanced in a system of free enterprise both for the benefit of the student and the country in which he lives. No one should encourage the principle of "getting something for nothing." A recent bill in the last Indiana Senate desired \$200,000 to donate to graduated nurses to continue post-graduate training. Had the bill passed, the investment returns would have been equivalent to "pouring water down a rathole", as far as helping the current, and future, shortage of student nurses in Indiana. The I.S.M.A. refused to support this bill since it did not specify that this money should be used in a "revolving loan fund". Give-away programs never consider the taxpayer and, too often, act as a front for our creeping socialism. If public officials and organizations spent their funds like

they spend their own money, taxes would be less and give-away programs would be tabooed.

Thus, the modern archetype of nursing and medical schools, the standards and requirements of organizations and boards, the principle and policies of the nursing and medical profession should integrate the practical medicine of yesterday with the scientific medicine of today, if we are to eliminate shortages in medical schools, hospital budgets, medical and nursing personnel.

Paul D. Grimm M.D.

P. S. "It is better to be able neither to read nor write than to be able to do nothing else", in a society of free enterprise, than to be able to read and write in a society of collectivism.

FIFTH ANNUAL RURAL HEALTH MEETING DRAWS RECORD CROWD



Those who participated in the presentation by the American Medical Association of special certificates to Dr. Franklin S. Crockett, Lafayette, and Mrs. Charles W. Sewell, Otterbein, were, left to right: Paul D. Grimm, M.D., Evansville, president of the Indiana State Medical Association; George S. Lull, M.D., Chicago, secretary and general manager of the American Medical Association; Mrs. Sewell; Doctor Crockett; and L. E. Hoffman, associate director of Agricultural Extension at Purdue and a member of the Indiana Rural Health Committee.

The certificates were presented in recognition of the services both the Lafayette physician and Mrs. Sewell have given to improve health and living conditions of persons in rural areas. The ceremony was held at the banquet concluding the Fifth Annual Rural Health Conference July 29.

CITIZENS of rural areas from throughout Indiana attended 11 unit meetings at the Fifth Annual Rural Health Conference of the Indiana State Medical Association held July 29 in co-

operation with the Summer Agricultural Conference at Purdue University.

Highlight of the program was the presentation of special certificates by the American

Medical Association to Dr. Franklin S. Crockett, Lafayette physician, and to Mrs. Charles W. Sewell, Otterbein, leader in state and national farm affairs for many years. The certificates recognized the effective work done by both recipients to improve rural health. Doctor Crockett has served as chairman of the A.M.A. Rural Health Committee for many years.

Speakers throughout the day discussed problems of health, safety, food, farm and home security and other related topics. More than 1,500 members of the Indiana Home Demonstration choruses presented the annual musical review.

Dr. Charles S. Cameron, medical and scientific director of the American Cancer Society, New York, speaking on "Facts About Cancer" said that people will have to become aroused about cancer to the same degree they formerly were over tuberculosis, typhoid fever and children's diseases before permanent results in the fight against the disease will be secured. Recounting accomplishments in medicine which have controlled most of the leading causes of death Doctor Cameron said so-called degenerative diseases top the fatality list today and that a disease which affects one in five persons, is a leading cause of death of children between 5 and 14 years old, and otherwise takes a heavy death toll

must be regarded as an epidemic and treated accordingly.

Dr. Harris B. Shumacker, Jr., Indianapolis, told the meeting on "The Heart of Life" that patients with certain types of heart ailments need no longer become invalids since surgical procedures have been developed which can help them. He discussed several recent advances in the treatment of heart disease.

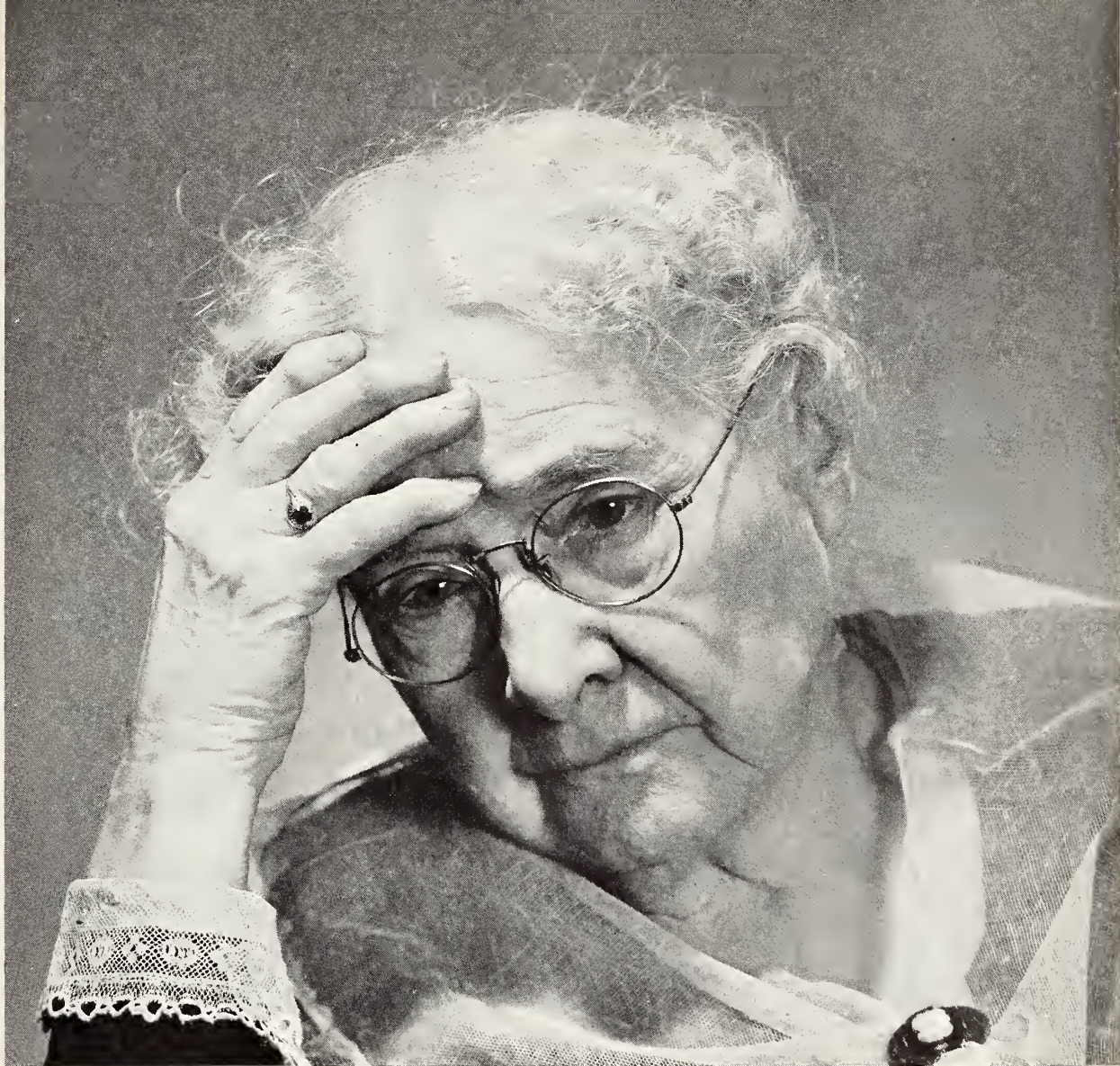
Other speakers included David Hartley, Indiana State Board of Health, who discussed food sanitation; Oliver Field, director of the Bureau of Investigation of A.M.A. who spoke on "Food Facts," pointing out that promoters of many health foods and fancy diets are actually today's "medicine men"; Dr. Harriet O'Shea, Purdue psychologist, who discussed emotional maturity; Dr. Howard G. Diesslin, Purdue agricultural economist, who emphasized careful insurance planning; and W. C. Moore, Lafayette attorney, who outlined the drawing of simple, understandable wills.

The Rural Health Conference was established in 1948 by the Rural Health Committee of Indiana State Medical Association and two years later joined with Purdue University to present the annual affair.

SCHEDULE OF SCHOOL HEALTH CONFERENCES

1953-1954 School Year

September 23	Oakland City
September 24	French Lick
October 9	Butler
October 14	Hanover
October 28	North Manchester
October 31	Valparaiso
November 4	Ball State, Muncie
November 4	Franklin
November 5	Evansville
November 13	DePauw



The inevitable restrictions of advancing years, the reduced activity and a lowered intake of bulk-producing foods all contribute to the high incidence of constipation in older persons.

CONSTIPATION IN THE AGED

Constipation is almost a universal complaint of geriatric patients

Frequently, too, the protracted use of cathartics has left the colon in an atonic state and it is no longer capable of effecting a normal evacuation.

Metamucil has long been recommended for the treatment of constipation in the elderly. A highly refined vegetable product which is free from irritants, Metamucil effects a natural mechanical stimulus in the colon which helps the dysfunctioning muscles to regain and maintain their normal tone.

Metamucil may be safely prescribed for prolonged use without fear of dependence, intestinal irritations or allergic reactions.

Metamucil® is the highly refined mucilloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

SEARLE *Research in the Service of Medicine*

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

STATE MEDICINE AND MR. EDEN

Anthony Eden, the British foreign secretary, who underwent an operation June 10 in a Boston hospital, is scheduled to fly back to London soon. His surgeon has reported that complete recovery is assured.

We rejoice in the foreign secretary's return to health and in the wisdom he displayed in coming to the United States for medical treatment. Government medicine, as practiced in Britain, obviously must not be good enough for high officers of the government.

—*Chicago Tribune.*

FOR MORE MEDICAL CARE

Because there is ample room for extension of medical services in the United States, some of the various ideas that are being proposed in Congress are of special interest.

There is little, or no, chance of "socialized medicine," as the term is generally known, being enacted under the Eisenhower administration. The President has stated his own opposition to it, and the Congress as now constituted is strongly against further attempts to establish a socialist state.

In fact, a new idea that has been presented to Congress is an alternative to socialized medicine. Its author is Rep. Bolton of Ohio, and the plan would allow everyone to deduct the full cost of all medical and dental expense at the time the federal income tax is computed. This would differ from the present method under which a taxpayer can deduct only that part of medical expense which exceeds five per cent of gross income.

Apparently there is merit in the Bolton plan, since an individual 30 years old, for example, should have the same right to deduct all his medical expense as the individual who is 65.

Yet it must be remembered that while the Bolton plan sounds good, the money to finance it would have to come from the American taxpayers. This is because taxes would have to be higher to make

up for the shrinkage in government revenue which the complete deductions in the Bolton plan contemplate.

There is another idea in Washington—proposed by Sen. Douglas of Illinois—which operates something like deductible auto insurance.

It would require all wage earners to bear the cost of illness up to some minimum figure—say \$250 a year. The individual would retain his medical payment receipts, and the government would reimburse him for medical costs over \$250.

The Douglas plan seems to us to be impractical, for it would tend to encourage a continuation of real and imagined disabilities if the government would pay the costs over \$250. Under this idea, for example, it might be possible for an individual to arrange to spend \$250 a year out of his savings, enter a hospital or other institution for his health and remain there indefinitely at the government's expense.

Many years ago old line insurance companies wrote total and permanent disability annuities and found it necessary to terminate this practice because of gross abuse and misrepresentations of the annuity holder's physical condition. The Douglas plan, it seems, might tend to encourage a revival of such a practice.

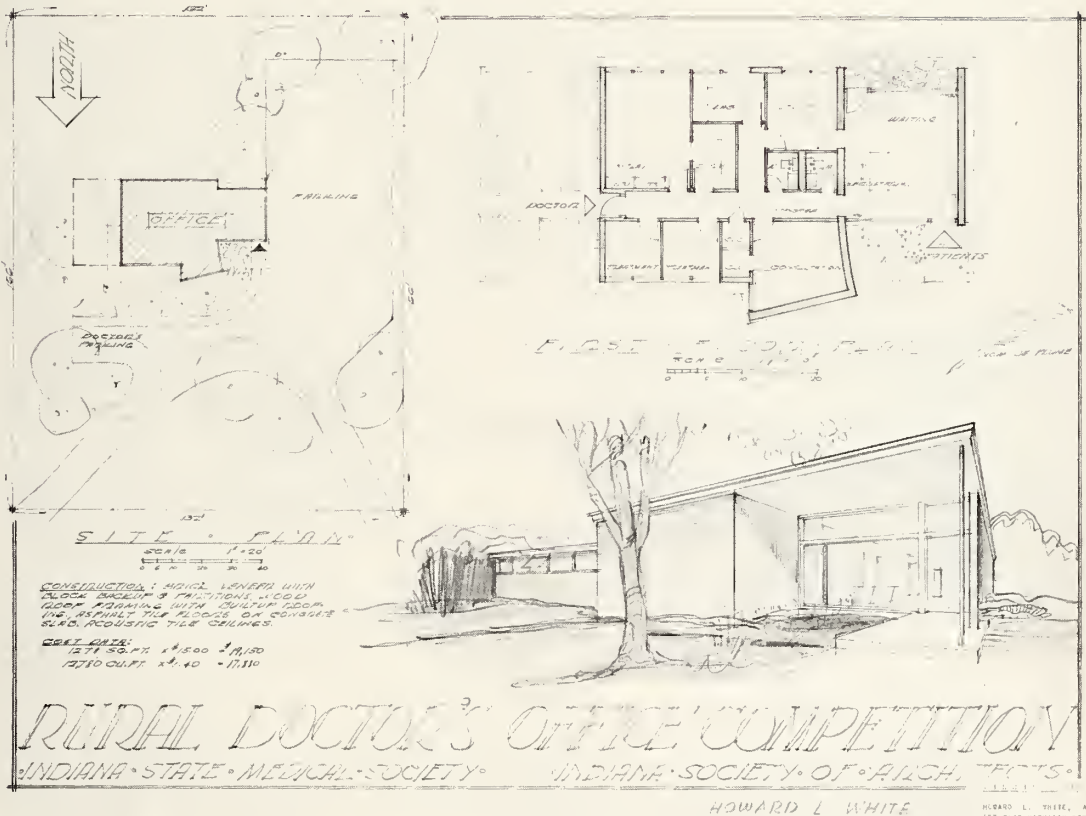
A feature of the Douglas plan that would not be liked by many people is that the government would figure in the background as a subsidizer. To get around this, one insurance company is reported coming out with "deductible" health insurance which would operate like the Douglas plan except that it would be voluntary and under private auspices.

Whatever the merits or demerits of any of these ideas, it is encouraging that men are giving time to studying means by which more people can have more medical coverage. The important thing is to extend medical services without risking federal control. Any government that gains control of the health of its people can, if it chooses, have the power of life and death over them. America is not a likely place for the government to attempt such a dictatorship, but the opportunity to do so should never be provided. No one knows when a strong-willed government, bent on socializing the nation, might come to power.

—*Kokomo Tribune.*

WINNING DESIGN FOR RURAL DOCTOR'S OFFICE

Competition Sponsored Jointly by Indiana State
Medical Association and Indiana Society of Architects



MEMBERS of a five-man jury representing the Indiana State Medical Association and the Indiana Society of Architects selected the accompanying plan submitted by Howard L. White, A.I.A., 122 East Michigan Street, Indianapolis 4, Indiana, as the winning design submitted in the competition initiated by the sponsors to stimulate interest and show ways and means of providing adequate and attractive facilities for rural medical practitioners.

The program was written to conform to the basic objectives of the Medical Association and generalized somewhat for possible application anywhere in the state of Indiana, Paul Jerne-

gan, A.I.A., chairman, said in announcing results of the competition. Plans are specific enough, he added, to be adapted to local requirements. Doctors who may be interested in possible construction of these competition, or similar, plans should contact the competitors individually, Mr. Jernegan said.

In the opinion of the jury the submissions were well done, workable and indicated an understanding of the scale and basic requirements of a doctor's office. There was some difficulty in proper separation of secretarial areas from the waiting areas. Parking facilities were amply provided for, and, with one exception, provision

HOWARD L. WHITE

HOWARD L. WHITE, A.I.A.,
122 EAST MICHIGAN STREET
INDIANAPOLIS 4, INDIANA

for future expansion was well integrated and practical. Cost estimates were, in many cases, slightly lower than the jury felt would be found to exist under actual construction conditions. However, in rural areas, they might properly apply.

Presentation was uniformly good and the jury felt that additional submissions would have been received had more time been given and had the competition taken place when the offices of the state were less crowded with current work.

The consensus of the jury was that those who made the effort to submit these drawings should be complimented for their cooperation.

Winning Design Discussed

The winning design, of all those presented, seems to have best solved the plan relationship and construction economy, the jury agreed. The future expansion was properly developed; the X-ray, laboratory, utility, dark room and toilets were grouped in a compact manner to insure economical mechanical costs. Relationship be-

tween consultation and waiting rooms was good; the exterior would present a simple and pleasant appearance. The principle criticism of this plan was the failure to separate the secretarial office area from the waiting area. This was considered not too serious, since it was only a matter of constructing a counter with glass enclosure to realize such separation. Jury comments indicated that an office secretarial area could have been developed easily in the front by moving slightly into the northeast corner of the planting area.

It was also noted that the competitor erred slightly in his exterior perspective which indicated a rectangular entrance area rather than the more attractive angular overhang with a slight curve to the west wall of the consultation room, as shown in plan. All in all, it was rated a buildable and attractive design.

Other Plans to Be Published

Four other designs submitted in the competition will be presented in subsequent issues of *THE JOURNAL*, together with brief descriptive details.

Members of the jury which studied the competitive plans were: Paul Jernegan, A.I.A., chairman; Warren D. Miller, F.A.I.A., past president, National Council of Architectural Registration Boards and member of the Indiana State Board of Registration for Architects; Frank Montana, A.I.A., head of the Department of Architecture, University of Notre Dame; Frank B. Ramsey, M.D., editor, *THE JOURNAL* of the Indiana State Medical Association; and James A. Waggener, executive secretary, Indiana State Medical Association.

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Albert J. Crevello, M.D., Medical Director

AUTOMATIC IRRIGATOR FOR INDWELLING GASTROINTESTINAL TUBES

W. D. DANNACHER, M.D.

Wabash

LESS THAN 25 years ago Dr. O. H. Wangenstein first introduced continuous gastric suction for the treatment of gastrointestinal distension. There have been few advances in the entire surgical field that can compare with the general acceptance of the nasal-gastric tube for gastrointestinal decompression.

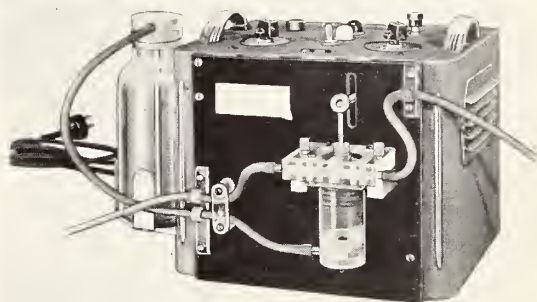
During the last 15 years progressive changes have been made in the methods of creating a constant, regulated type of suction. At first there were elaborate "bottle" type machines but these have been replaced rapidly by more dependable and efficient mechanical pumps and an ingenious thermo-pump. There also have been many improvements in both the short "Levine" type indwelling tube and the long "Miller Abbott" type intestinal tube.

Thus, by regulated continuous suction from an indwelling gastrointestinal tube, swallowed air, accumulated gastric juices and succus entericus can be removed. Intestinal distension is relieved and a vicious cycle of pathological events is broken up.

It has been shown that the weakest link in the chain of present day technic of intestinal decompression is the frequent plugging of the indwelling tubes with mucus, blood clots and fecal matter. Even with our best suction apparatus and latest design of indwelling tubes, frequent irrigation is needed to assure efficient decompression. Under ideal conditions, where nurses or interns are able to irrigate these tubes manually every hour, there is still much to be desired. The tubes may block themselves the first five minutes of the hour and there may be 55 minutes of inefficient suction. In most hospitals where general duty nursing care is used and there are no interns, several hours may elapse between irrigations.

A blocked indwelling tube is a constant source of anxiety and tension to the nursing staff and attending surgeon. Irrigating tubes by hand is often a messy procedure. Frequently, inexperienced aides will put down large quantities of water and get very reduced returns.

An automatic irrigating machine called the "Irri-Mat"* has been developed to offer safe,



Automatic irrigating machine, above, increases efficiency of intestinal decompression with gastrointestinal suction tubes.

dependable irrigation of indwelling gastrointestinal tubes. The machine can be used with any conventional suction apparatus.

After several months of use it was noted that time intervals of 10 or 20 minutes, using one to two ounces of water, was the most desirable method of automatic irrigation. However, the amount of irrigating fluid can be increased when long intestinal tubes of the "Miller Abbott" type are used. Water is drawn from a 500 cc. reservoir through a pump which has force enough to remove any recent obstructive particles or mucus. When the pump is working a valve mechanism shuts off the suction apparatus. When the irrigation is completed the valve again opens the suction circuit. There is also a manually operated switch which will cause the machine to irrigate as long as the contact is held down. This manual switch does not

* Manufactured by Laboratory Specialties, Inc., Wabash, Indiana.

interfere with the pre-set automatic cycle. Frequent irrigations eliminate the lost efficiency of suction that results when the tube is blocked a few minutes after it has been opened. Records can be kept of the number of times the reservoir bottle is filled.

It must be understood that frequent irrigation of stomach and bowel will result in increased loss of electrolytes.

Dr. Frederick Taylor¹ has shown in recent studies at the Indianapolis Veterans Administration Hospital that about 15 grams of total chlorides were lost in four liters of gastric washings over a 24 hour period. With the automatic irrigator the 24 hour gastric washing will be between three and a half to five liters. Thus, at least one and a half to two liters of normal saline solution should be used daily if parenteral feedings with continuous gastric suction and automatic irrigations are used. Certainly it is advisable to check the urine chloride by the Fantus test, or check the serum chlorides by chemical analysis, after continuous suction and irrigations are used over two or three days.

It is also an important factor in gastrointestinal decompression to be sure that the open end of the indwelling tube is in the dependent portion of the stomach and not curled up in the cardia. This is a simple but frequent source of failure to maintain effective decompression even with adequate irrigation. Also, it is well to mention that all rubber tubes used must be free from "kinks" and twists where they are fastened to the nose and bed and also from external pressure where the tubes cross a hard surface.

Conclusion

The "Irri-Mat" increases the efficiency of intestinal decompression with gastrointestinal suction tubes and thus has met with approval by surgeons. It has been welcomed by nursing and house staffs in hospitals as a great time saver for personnel.

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A. M. A. Washington Office News

Proposed Treaty Amendments Protect State Licensing Laws. The Senate Foreign Relations Committee has received assurances from State Department officials that in negotiating future bilateral treaties the administration will seek to write in exemptions for the professions, including medicine, from the most-favored-nation clause. A number of professional groups have been concerned over treaties that granted reciprocal rights for practice without regard to state licensing regulations. The issue came up during hearings on pending treaties of friendship and commerce with Japan, Israel, Denmark, Greece, Ethiopia, and West Germany.

One proposal drawn up by the Senate committee states that reciprocal national treatment would not be extended "to professions which, because they involve the performance of functions in a public capacity or in the interest of public health and safety, are state licensed and reserved by statute or constitution exclusively to citizens of the country, and no most-favored-nation clause in the said treaty shall apply to such professions." State Department officials said they would make every effort to negotiate such a reservation in future treaties and if the Senate desired, it could send the pending treaties back for renegotiation.

Federal Survey Shows Abuse of Veterans Hospitalization. Abuses by veterans with non-service-connected disabilities in applying for VA hospitalization were detailed in a government survey placed before the House Veterans Affairs subcommittee. It wound up hearings on non-service cases July 21. The testimony came from two *General Accounting Office* officials who reported on a survey they made last year of 46 VA hospitals. GAO investigators selected about 350 recently discharged cases where VA records disclosed "strong presumptive evidence of ability to pay." They found incomes ranging from \$4,000 to \$50,000 a year, with 25 of these having real property and other assets between \$20,000 and \$500,000.

The GAO concluded: "It is clear that there are veterans being hospitalized on the basis of the unable-to-pay affidavit prescribed in the present law who are fully able to pay for their hospitalization and others who are able to pay in part . . . The present law and regulations in effect discriminate against the more honest class of applicant. In short, the veteran of ordinary circumstances must either perjure himself or be deprived of a benefit freely given to other veterans similarly circumstanced, perhaps less worthy of care at public expense."

The subcommittee was urged by the *American Hospital Association* to recommend legislation that would determine which veterans with non-service-connected conditions are medically indigent and therefore eligible for VA care. William S. McNary, chairman of the AHA Council on Government Relations, also stated: (1) Congress should vote no further expansion of VA hospital system if quality of care is to be maintained, (2) number of beds now available in VA hospitals is more than adequate to meet need of veterans with service-connected disabilities, and (3) any new construction simply will be for care of disabilities having no service-connection.

AMA Stand on Non-Service VA Care Outlined to House Group. American Medical Association's opposition to further treatment in VA hospitals of veterans with non-service-connected disabilities, other than tuberculosis or neuropsychiatric disorders, was formerly placed before Congress July 13. Dr. Walter B. Martin, president-elect, was opening witness on the fourth day of

hearings by the hospitalization subcommittee headed by Rep. B. W. (Pat) Kearney (R., N. Y.). The group is inquiring into hospital entitlement of veterans.

Dr. Martin made it clear that Congress should enact legislation limiting medical and hospital care for veterans in VA and other federal hospitals to (1) men with peacetime or wartime service whose disabilities or diseases are service-connected and (2) within limits of existing facilities, to veterans with wartime service suffering from tuberculosis or neuropsychiatric disorders of non-service origin who are unable to pay for hospitalization. He further proposed that (1) care for the remaining non-service veterans be discontinued and their responsibility revert to the individual or in the case of the indigent veteran, to the community and (2) Congress reanalyze the entire question of whether the non-service chronically ill is a federal or local responsibility.

Acting VA Administrator H. V. Stirling argued, on the other hand, that to exclude veterans with acute non-service disorders who aren't eligible for compensation or pension would be "a substantial reversal of long-existing legislative policy." He said it would require the determination that "the government owes no obligation of this kind to these veterans, however indigent."

Points made by other witnesses included:

National Medical Veterans Society (Dr. William B. Walsh): Should eligibility for hospitalization remain as broad as it is now, the burden on the public by 1970 will reach fantastic proportions. *American Dental Association* (Francis J. Garvey): The association opposes VA care for the non-service-connected tooth and "firmly believes that the obligation to care for one's health is primarily the obligation of the individual." *American Psychiatric Association* (Dr. David J. Flicker): Under present VA policy, it is becoming increasingly difficult to staff enough neuropsychiatric beds for non-service-connected veterans.

AMA Supports Deductions for Postgraduate Expenses. Dr. Walter B. Martin, AMA president-elect, strongly urged Congress to consider amending the tax law to allow deduction of postgraduate educational expenses. Dr. Martin recalled a U.S. Court of Appeals' decision in which an attorney was permitted to deduct expenses in attending postgraduate courses on taxes. Dr. Martin, testifying for the AMA, told the House Ways and Means Committee:

"While it is the belief of the American Medical Association that this decision probably applies to the practicing physician who attends postgraduate courses similarly designed to refresh his medical knowledge and to keep him informed regarding recent medical developments, it is by no means clear that the decision covers attendance at courses designed to advance the physician into a new era of his profession . . . It is the belief of the Association that the issue should be settled by new legislation rather than be left to administrative interpretation or judicial decision."

VA Abandons Hope of Collecting on 'Exclusion Clauses.' Veterans Administration apparently is convinced that hospital insurance plans cannot be forced to drop "exclusion clauses," provisions which relieve the insurer of liability for payment to VA hospitals. VA's position was stated in a letter by Vice Admiral Joel T. Boone, chief medical director, to Rep. Alvin M. Bentley (R., Mich.). Admiral Boone described various ways in which hospitalization policies were able to exclude payments to VA for non-service connected cases, and other factors that made it difficult for the agency to collect from insurers. He added:

"It is safe to say that most of the policies currently being written contain some of these or similar exclusion clauses. There is nothing illegal about this. The parties have a right to contract as they please. No state insurance commission, or other regulatory body, or governor, would have any legal authority to require such insurance companies to insure a risk they do not want to insure."

This announcement followed various unsuccessful attempts to force state officials to outlaw VA "exclusion clauses." Earlier VA had announced that it would make no further effort to collect on policies carrying such clauses.

INDIANA UNIVERSITY SCHOOL OF MEDICINE PLANS GOLDEN ANNIVERSARY SEPTEMBER 29

LOOKING FORWARD to another half-century of progress and service in medical education, the Indiana University School of Medicine is commemorating on Tuesday, September 29, the fiftieth anniversary of its founding.



Dr. Bryan, I. U. President Emeritus

It was just 50 years ago, in September 1903, that William Lowe Bryan, now president emeritus of Indiana University, welcomed the first students of the new school of Medicine to the University campus at Bloomington. Both Dr. Bryan and several members of that first class, graduated in

1907, will be among the honored guests at the golden anniversary dinner.

Alumni and medical educators from all parts of the nation will return to the University's Medical Center campus in Indianapolis for the anniversary ceremonies which will be followed by the sixth annual Alumni Day of the School of Medicine and the formal dedication of the new Union-Food Service building, one of the major additions to the facilities of the Medical Center.

The annual Alumni Day program will be held September 30, with registration and a business session in the morning to be followed at noon by the traditional picnic on the campus and class reunions. Special recognition will be given this year to the Medical School classes graduating in 1908, 1913, 1918, 1923, 1928, 1933, 1938, 1943, 1948, and 1953. Reunion sessions will also be held by other classes. Dr. Dillon Geiger, Bloomington, will be succeeded as president of the Medical Alumni Association by Dr. J. O. Ritchey, Indianapolis.

Immediately following the alumni reunions will come the ceremonies dedicating the new

Union-Food Service building as one of the major contributions to the further development of the University's Medical Center and other units in Indianapolis. In this eight-story building of modern functional design is combined food service, living and recreation facilities for students, faculty and staff and for physicians and others returning to the campus for postgraduate study and conferences. It also provides accommodations for outpatients and for relatives of patients.

It was in March, 1903, that Dr. Bryan, then in his first year as president of Indiana University, proposed to the Board of Trustees that immediate steps be taken to establish a School of Medicine. In conferring University status on the institution in 1838, the General Assembly had specified that instruction in medicine be provided. However, no funds were made available for this purpose and efforts toward medical education in the '70's were abandoned because of financial difficulties.

The resources of the University were still inadequate when Dr. Bryan made his proposal to the trustees and pointed out that, "In the best cases, the medical school is not an independent institution affiliated with the University, but is an integral part of the University."



Dr. Myers, first Dean of the I. U. School of Medicine

The trustees approved Dr. Bryan's proposal and Dr. Burton D. Myers was brought from Johns Hopkins University to head the new venture. A two-year medical course was instituted in the fall of 1903 with classes in human anatomy and physiology added to previously established work in chemistry, microscopic anatomy and embryology.

The new school became a member of the Asso-



STARTED HERE—Owen Hall on the Bloomington campus is where the Indiana University School of Medicine was started 50 years ago. One of the oldest buildings on the campus it now is headquarters for the Department of Geology but many of the state's physicians had their first professional training in Owen Hall.

ciation of American Medical Colleges and was accepted by the Indiana State Board of Medical Registration. In addition to its two-year course, a two-year pre-medical course had been established and the School was ready for expansion. This opportunity came through the acquisition of the Indianapolis building formerly occupied by the Central College of Physicians and Surgeons. This gave the University an excellent building in which to establish the last two years of a medical course.

In 1906, Dr. Myers reported an enrollment of 109 students; 37 freshmen; 20 sophomores; 27 juniors, and 25 seniors. At the commencement exercises on May 18, 1907, President Bryan awarded M.D. degrees to 24 medical graduates.

Subsequently other medical schools were merged with the University School of Medicine and for a time four years of medical education were offered at Indianapolis and a two-year course at Bloomington. In 1912 it was decided to offer only the first year at Bloomington with the sophomore, junior and senior years to be given at Indianapolis.

Another expansion took place in 1912 when

Dr. Robert W. Long offered funds for the establishment of a teaching hospital to be maintained in connection with the University's School of Medicine and available to patients from all parts of the state. This offer was accepted and the hospital, named for the donor, erected on its present site. In 1919 the School of Medicine was transferred from the downtown location to its present site and enlarged nine years later by the addition of a wing holding offices and an auditorium.

Thus the foundation was laid for the development of the University Medical Center as it exists today. In rapid order came the Riley hospital for children, the Coleman hospital for women, the Ball Residence and Training School for Nurses, the Kiwanis wing at Riley, the Rotary Convalescent Home, the Clinical building, the Riley research wing and the Laboratory-Science building.

Today the new Union-Food Service building is taking its place on the campus and a cancer research unit is being completed. And, as the School of Medicine begins its second half-century of service to the people of Indiana, plans are being drawn for a new Medical Science building which will provide adequate space and facilities for medical education and the education of other young men and women for service to their fellowman in the various health fields.

Below, Dr. John D. VanNuys, present Dean of the School of Medicine.



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"Reeling and Writhing, of course, to begin with," the Mock Turtle replied," and the different branches of Arithmetic—Ambition, Distraction, Uglication, and Derision."

REMEMBERING those delightful lines so vividly may have been one of the reasons Lall G. Montgomery "chortled with joy" when, as a graduate medical student he was told it would be of great help in learning the German and French languages to read "Alice in Wonderland" in those tongues. Learning to speak German and French was required so the young Canadian medical student obtained copies of Lewis Carroll's immortal story in those versions, placed each individually beside the English edition and remembering that if you "take care of the sense, the sounds will take care of themselves," soon had a working knowledge of the two languages.

And thereby hangs a tale.

Today Lall Montgomery, M.D., pathologist at Ball Memorial Hospital, Muncie, is the owner

of a truly fabulous "Alice in Wonderland" collection (Technically, we should say "Lewis Carroll" collection but everyone knows "Alice" while many have forgotten her creator.)

Doctor Montgomery has more than 700 copies of "Alice" in his country home near Muncie. These are no ordinary "Alices"—they include the one in Braille, pictured here, two in shorthand, copies in Gaelic, Hebrew, Chinese, Esperanto, Serbian and Russian and in all of the European and Scandinavian languages. The copy in Serbian bears the signature of Alice Liddell Hargreaves to whom Lewis Carroll told his "Alice" story many years before it was printed.

Not satisfied merely to possess the volumes, Doctor Montgomery has learned Braille so that he may read "Alice" as a sightless person would



A Braille edition of "Alice in Wonderland" is in the foreground with Alice and the March Hare looking over other rare editions of the classic.



Figurines of familiar characters from the Carroll book (including the Mock Turtle carved by Doctor Montgomery) stand before a French version of "Alice in Wonderland".

do; he has learned shorthand so those little hieroglyphics would bring "Alice" to life; he has learned "to talk of many things" about the people of other lands—for instance, in those early encounters with foreign "Alices" he found the stolid Germans, not always understanding the subtle humor, left out some lines while the French, if puzzled, gave their own interpretations of the Carroll lines, sometimes even improving them.

Doctor Montgomery's collection is rated as one of the four most valuable in existence.

As collectors often do, he has expanded his collection to include many of the well-known characters in the book done in porcelain and wood, some rare, all interesting. Among the figurines is one of the Mock Turtle which Doctor Montgomery carved himself. Friends add constantly to the collection. From the paper cutouts and puppets his own children give him at Christmas to the three original drawings and three color copies the Walt Disney Studios sent



Elizabeth Montgomery drops off to sleep curled up in a chair with "Alice".



Doctor Montgomery looks over one of the three original drawings sent to him by the Walt Disney studios. They also added three color prints to the Muncie doctor's collection.

him from their "Alice in Wonderland," the Muncie doctor derives much pleasure. His collection contains one of the original drawings for the first edition of the Carroll book.

This affair with "Alice" is no selfish thing—the entire Montgomery clan eagerly talks over each addition.

The Montgomery home is in the middle of a small forest where each year after a family conclave they select and cut their own Christmas tree; where each spring they tap some sugar maples and make syrup (that came about when the oldest daughter asked how maple syrup was made so she might write a theme about it); where a little later they enjoy their garden, which Doctor Montgomery adds is the kind he likes, one you can plant and forget about until you cut the blooms. That's an understatement because the Montgomerys have what is probably the largest daffodil bed in the state—at least 250 varieties and from 50,000 to 100,000 bulbs.

In between times, they sing—all of them. Their specialty is rounds and catches (in which the words are arranged to produce ludicrous effects) and even the smallest can learn a part. They can't compare with the Trapp family, Doctor Montgomery says, but he is sure they have as much or more fun.

Being briefly biographical — Doctor Montgomery received his degree in medicine at the University at Manitoba, was licensed in Canada in 1929, certified by the American Board of Pathologists in 1937, is a member of many special medical groups in which he has held office, served last year as chairman of Section on Pathology and Physiology of the American Medical Association and is an associate editor of *THE JOURNAL* of Indiana State Medical Association.

Mrs. Montgomery, the former Edith Marion Reed, is a Mount Holyoke graduate and daugh-



Here, the doctor and his oldest daughter gather the sap from one of their sugar maples. Tapping their trees and making a limited amount of maple syrup each spring is another Montgomery avocation.

ter of the vice president of Johns Hopkins University. The four children, three girls and a boy, range from 14 to 1, with the boy "in the middle".

"We have a very pleasant life together," Doctor Montgomery says.

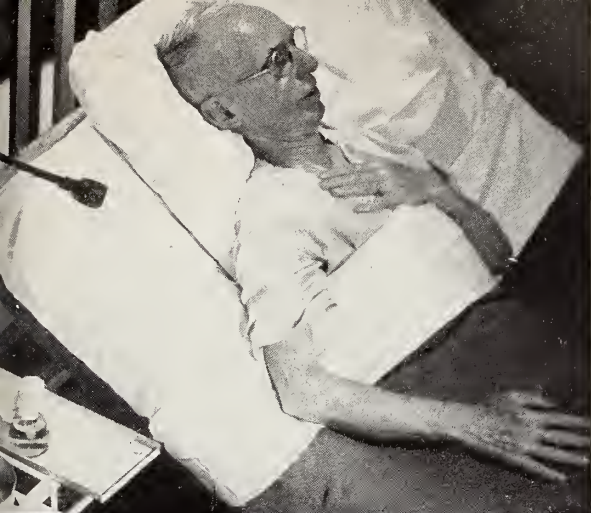
If the Duchess (who told Alice, "Tut, tut child, everything's got a moral if only you can find it") could comment she'd probably say the moral to this story is that such happiness is found wherever people keep busy and interested.

Doctor Montgomery has his profession—his family—and Alice, maple syrup, daffodils and music.

J.S.G.

Addendum

This is the first of a series of stories about what Hoosier doctors do for relaxation from the strenuous lives their profession demands. Another, vastly different, account will be published soon. The frequency with which the stories appear depends upon response from the doctors themselves. The first two were requested to get the feature started. It is hoped modesty will not prevent many Hoosier doctors from telling us the story of their hobby.



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1. Ferguson, C., and Miller, C. D.: J. Urol. 67:762 (May) 1952.

2. Trafton, H. M., and Lind, H. E.: Ibid. 69:315 (Feb.) 1953.

3. Blahey, P. R.: Canad. M. A. J. 66:151 (Feb.) 1952.



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Deaths

Boaz Yocum, M.D., 85, who retired in 1949 after nearly a half century of practice in Coal City, Owen county, died July 17 in Union Hospital, Terre Haute, where he had been critically ill only a few days. A native of Kentucky, Doctor Yocum received his degree in medicine at the Louisville Medical College in 1893 and practiced briefly in Clay City, Lyons, Arney and Quincy before establishing his office in Coal City in 1900. Doctor Yocum was a senior member of the Owen County Medical Society and the Indiana State Medical Association. He had been active also in church and lodge work.

Doctor Yocum was the father of Paul Yocum, M.D. and William Yocum, M.D., both in practice at Gary, and Richard Yocum, M.D., now in Chillicothe, Ohio.

Ivan E. Brenner, M.D., Winchester physician and surgeon since 1914, died in his home

August 4 from a heart ailment which had restricted his activities since last December.

Doctor Brenner, who specialized in thyroid surgery, was a 1913 graduate of Indiana University School of Medicine and had done research work in Boston, London, Vienna and Berlin. He was born in Morocco in 1887.

He was a member of the Randolph County Medical Society, which he served as secretary for several years, the Indiana State and American Medical Associations and the American College of Surgeons.

Edwin D. Stuckman, M.D., 85, who had practiced medicine for 58 years in New Paris, died July 18 in the Goshen Hospital where he had been a patient for 11 days. He had been active until two months before his death.

Born in Nappanee, Doctor Stuckman was graduated from the Medical College of Indiana

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Anesthetic in Hospital.....	10.00	20.00	30.00	40.00
X-Ray in Hospital.....	10.00	20.00	30.00	40.00
Medicines in Hospital.....	10.00	20.00	30.00	40.00
Ambulance to or from Hospital.....	10.00	20.00	30.00	40.00

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at Indianapolis in 1895 and established his practice in New Paris that year.

Doctor Stuckman was a senior member of the Elkhart County Medical Society and the Indiana State Medical Association. He had received his Fifty Year club pin and certificate from I.S.M.A. in 1944.

Following an illness of several months duration, **Harry H. Alexander, M.D.**, Princeton, died in the Gibson General Hospital on July 29. He was 74 years old and had practiced in Princeton for 49 years. Born in Bicknell, Doctor Alexander had lived in Princeton since June, 1904 when he received his medical degree from the Kentucky University Department of Medicine at Louisville. His offices had been in the same location for the entire period. Doctor Alexander specialized in obstetrics and pediatrics.

He was a member of Gibson County Medical Society, the Indiana State and American Medical Associations and had been an active member of his church, lodge and service club. He was a former member of the Princeton school board and at the time of his death was serving as chairman of the Princeton board of health.

John W. Shafer, M.D., 80, retired Lafayette physician and surgeon, died July 10 in Home Hospital, Lafayette. He had been in ill health since 1948. Born in Newton County, Doctor Shafer was graduated from Rush Medical College in 1900 and practiced in Morocco for two years before going to Lafayette. He served as a captain in the Medical Corps during World War I, had been on the Home Hospital staff and a member of the Lafayette city council for eight years. He also had served as president of the Morocco State Bank for the last 15 years. Doctor Shafer was a senior member of Tippecanoe County Medical Society, the state and national medical associations.

Claude C. Lomax, M.D., 69, who had lived in Costa Mesa, California, for the last two and a half years, died there July 13 following a long illness. Former resident physician at St. Meinrad Abbey and a practicing physician in Dale and Holland, Doctor Lomax then lived in In-

Elmer L. Henderson, M.D., 68 year old Louisville surgeon, died July 30 after a long illness.

Doctor Henderson had achieved almost every honor which the medical world can bestow. He had been president of his Jefferson County Medical Society, president of Kentucky State Medical Association; president of Southern Medical Association and the Southeastern Surgical Congress simultaneously; president of the American Medical Association and president of the World Medical Association; was chairman of the Board of Trustees of the A.M.A. and chairman of its executive committee.

In 1948 Doctor Henderson became chairman of a Campaign Coordinating Committee set up by the A.M.A. House of Delegates to direct a national education campaign against the socialization of medicine. With 11 other prominent physicians he worked effectively for four years against political medicine.

Doctor Henderson was a frequent speaker in Indiana and had a wide acquaintance among doctors of the state.

dianapolis before going to California because of ill health. Son of the late William Lomax, M.D., he was a native of Bristow, Perry county, and received his medical degree at Louisville and Hospital Medical College in 1908. He was a member of both Indiana State and American Medical Associations.

Frank B. Fisk, M.D., 70, who retired in 1952 after 39 years of service with the Pitman-Moore Company, Indianapolis, died suddenly July 10 in Tarrytown, New York, shortly after returning from a trip to Europe. Doctor Fisk was both a graduate pharmacist and a physician. He came to the pharmaceutical manufacturing firm in 1913 following his graduation from the Chicago College of Medicine and Surgery. At Pitman-Moore he first was in charge of pharmaceutical development, then pharmaceutical production and quality control. He was a member of Indianapolis Medical Society, the Indiana State and American Medical Association and had been active in the American Pharmaceutical Manufacturers Association.

News Notes

Chest Physicians Plan New York, Chicago PG Courses

The Eighth Annual Postgraduate Course on Diseases of the Chest will be held in the Hotel Knickerbocker, Chicago, September 28-October 2, and the Sixth Annual PG Course on Diseases of the Chest is scheduled for November 2-6 in the Hotel New Yorker, New York City. The courses endeavor to bring physicians up to date on recent advancements in the management and treatment of heart and lung disease. Tuition for each course is \$75 and full details may be secured by writing to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

Dr. C. P. A. Zerfas, who has recently returned from service aboard the *Essex* in Korean waters, is assigned to the Naval Ordnance Plant, Indianapolis. He was in private practice in Indianapolis from 1948 until 1951 when he was recalled to naval duty. He is a graduate of I. U. School of Medicine, interned at Indianapolis General Hospital, and lives near Indianapolis.

Dr. Oscar M. Helmer, biochemist for Eli Lilly and Company, flew to London July 25 where he will take part in an international symposium on "The Humoral and Neurogenic Factors in Hypertension." Four other Americans will join in the 25-man discussion. Doctor

Helmer will visit hospitals and medical research laboratories in Oslo, Stockholm and Copenhagen before returning.

The American Goiter Association again offers the Van Meter Prize Award of \$300 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting in Boston, April 29-May 1, 1954. Essays may cover either clinical or research investigations, should not exceed 3,000 words, be presented in English and sent typewritten and double spaced in duplicate to the Corresponding Secretary, Dr. John C. McClinck, 149½ Washington Avenue, Albany 10, New York, not later than January 15, 1954. The essay may be presented by the author at the annual meeting and will be published in the annual proceedings of the Association.

The South Dakota Board of Medical Examiners has announced the passage of legislation creating an annual registration fee for licensees in that state in the amount of \$2.00. The registration takes effect January 1, 1954. Any doctor licensed in South Dakota who wishes to maintain that license should contact the South Dakota Board of Medical Examiners, 300 First National Bank Building, Sioux Falls, South Dakota, according to an announcement by John C. Foster, executive secretary.

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Simon S. Rubin, M.D., 504 Broadway, Gary, has been elected secretary-treasurer of the Chicago Society of Allergy for 1953-54.

A scientific program, interesting exhibits, refresher course for technologists and roundtable and panel discussions led by national and international authorities are to be featured on the Sixth Annual Meeting of the **American Association of Blood Banks** in the LaSalle Hotel, Chicago, October 17-20. Additional information may be secured from the office of the Secretary, American Association of Blood Banks, 3500 Gaston Avenue, Dallas 4, Texas.

Dr. Theodore D. Rhodes, Indianapolis dermatologist, is convalescing from a myocardial infarction at his home, R.R. 12, Box 241, Indianapolis, and reports that he will be in temporary retirement for about a year.

The **American Urological Association** offers an annual award of \$1000 (first prize of \$500, second prize \$300 and third prize \$200) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been in such specific practice for not more than 10 years, and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Waldorf-Astoria, New York City, May 31—June 3, 1954.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles

Street, Baltimore, Maryland. Essays must be in his hands before February 1, 1954.

Indiana Doctors Named A.M.A. Section Officers

At the elections held by the various sections of the American Medical Association at the Annual Convention in New York, Hugh A. R. Kuhn, M.D., Hammond, was named secretary of the Section on Laryngology, Otology and Rhinology.

Lall G. Montgomery, M.D., Muncie, who served as chairman of the Section on Pathology and Physiology last year, was named delegate from the section to the A.M.A. House of Delegates.

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\$15,000 Fund Set Up for Basic Medical Science Research

Research in the basic medical sciences has been given a monetary boost. A grant of \$15,000 from the William Volker Charities Fund of Burlingame, California, recently was accepted by the American Medical Association for research in this area of medicine. The AMA's Committee on Research, through its sub-committee on grants-in-aid, will be responsible for allocating the monies—in grants of from \$500 to \$1,000—to individual investigators conducting studies in the various basic sciences, such as anatomy, physiology, embryology. It has been felt that too much attention has been paid to clinical applications of disease treatment and not enough to action of the human body's normal cells and organs. Grants from the "William Volker Fund" should help to stimulate a more realistic balance between these two important phases of medicine.

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Dr. Claude E. Davis, who has practised in Charlestown for a year, has opened an office for the general practice of medicine in Milltown. Doctor Davis is a graduate of Louisville School of Medicine and interned at St. Elizabeth Hospital, Lafayette. He has remodeled a large home to use as a residence and office quarters.

Dr. Norman N. Holtzman, who received his degree from the University of Illinois, and interned at Cook County Hospital, Chicago, has established an office for general practice at 3123 South Michigan Street, South Bend.

Dr. William R. Shaffer, native of Danville, Illinois and a graduate of the University of Louisville School of Medicine, has announced that he is now located in rooms formerly occupied by Dr. William Sallee in Greensburg. Doctor Shaffer has served for the last two years as an officer with the U.S. Public Health Service in San Juan, Puerto Rico.

Dr. Walter O. Erxleben, who completed a year as chief resident surgeon at St. Vincent's Hospital, Indianapolis, in May, has opened offices in Batesville where he will practice general medicine and surgery. Doctor Erxleben, native of Michigan, received his M.D. from University of Michigan Medical School in 1932, where he also served his internship and residency. He then took postgraduate work in Berlin and Munich, Germany. Doctor Erxleben established his practice in Chicago where he practiced for 15 years interrupted by two years service in the Army.

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Dr. Fred Harless has opened offices in Monroeville for the general practice of medicine following completion of his internship at Memorial Hospital, South Bend. He is a graduate of Indiana University School of Medicine.

Winchester was scheduled to have a new doctor August 1 when **Dr. Howard W. Koch** moved into offices at the corner of Washington and East streets. A native of Evansville, Doctor Koch received his degree in medicine from Indiana University School of Medicine and interned at Indianapolis General Hospital. He served for four years with the Army Air Force during World War II.

Dr. Richard G. Horswell has returned to Bristol to resume his practice in association with Dr. Edward Niedballa after completing 26 months service with the U.S. Naval Reserve. He first established practice in Elkhart county in 1940.

Dr. John H. Ivy, Chicago, has joined Dr. T. A. Elliott, Elkhart, in the practice of internal medicine. Doctor Ivy received his degree from Northwestern University Medical School, Chicago, after which he spent two years in the Air Force. Returning in 1948, he was with the department of experimental medicine at Northwestern for nine months and has since served four years as a fellow in internal medicine at the Mayo Clinic, Rochester, Minnesota.

Dr. Ronald H. Hull, who completed his residency at Larue D. Carter Memorial Hospital in the spring, has been certified by the American

Board of Neurology and Psychiatry. Doctor Hull left his position on the Carter staff July 15 to enter the private practice of neurology and psychiatry. He is associated with Drs. Murray DeArmond and Dwight Schuster at 723 Hume Mansur Building. Doctor Hull, who is a native of Indianapolis, is a graduate of I. U. School of Medicine.

Dr. Frederick R. Brown, who had been in practice in Ellettsville for the last year, closed his office August 8 and will move to the southwest for reasons of health. Doctor Brown is an I. U. graduate and son of the late Dr. A. P. Brown, Princeton.

Replacing **Dr. Robert Hayes** as resident physician at the Wabash Railway Employees Hospital, Peru, is **Dr. L. D. Lewis**, who recently completed his internship at Methodist Hospital, Indianapolis. He is a graduate of I. U. School of Medicine. Doctor Hayes has joined the U. S. Air Force.

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School Health Leaders Invited to A.M.A. Conference

School bells will toll again this fall for the American Medical Association's fourth national Conference on Physicians and Schools. Sponsored bi-annually by the Bureau of Health Education, this year's Conference will be held September 30, October 1-2 at the Moraine Hotel, Highland Park, Ill. More than 200 representatives of state health departments, state education departments and state medical societies have been invited to participate in discussions covering various topics of current importance in the school health field. Following the theme of "Health Services for School Children," the attendees will break up into a dozen different groups to tackle specific problems and develop suggested policies and practices. In addition—medical, public health and educational leaders from 18 large cities will discuss big city problems in school health.

The Doctors, Druggists and Dentists picnic was held by members of those professions in Vanderburgh county on August 27 at the West Haven Gun Club.

Applications for grants from the James Picker Foundation for Radiological Research, headed by Mutual Security Director Harold E. Stassen, may now be submitted for next year. Awards of grants, fellowships and scholarships are given in support of a specific research program under the direction of a responsible investigator. Applications should be directed to: James Picker Foundations, Inc., Hanover Bank Trustee, 70 Broadway, New York 4, New York, or Secretary, Division of Medical Science, National Research Council, 2101 Constitution Avenue, N. W., Washington 25, D. C. Final applications should be submitted no later than November 30, 1953.

Dr. John L. Cullison opened his offices for the general practice of medicine at 1600 West Jackson street, Muncie, July 27. He was a 1952 graduate of I. U. School of Medicine and interned at the I. U. Medical Center, Indianapolis. He is a resident of Muncie.

Dr. Harold O. Murphy, formerly of Franklin, opened offices July 1 in the Warsaw Clinic and will be affiliated with McDonald Hospital, Warsaw. Doctor Murphy is an I. U. graduate and served two and one-half years in the U. S. Navy. He will practice general medicine and surgery.

Dr. Harrison Green, who has been in private surgical practice in Indianapolis, and also served as a Marion County deputy coroner, has reported for active duty with the U.S. Navy at Oakland Naval Hospital, Oakland, California.

Dr. Charles E. Sheets, 1952 I. U. School of Medicine graduate, is practicing general medicine in Manilla. He served his internship at Methodist Hospital, Indianapolis.

Dr. Paul Humphrey, Terre Haute has announced that **Dr. John B. Hamsher**, urologist, is now associated with him in practice. Doctor Hamsher, graduate of the University of Cincinnati College of Medicine, has been in Memphis for three years where he was resident physician in urology at the University of Tennessee Hospital. Previously he had served his internship at Indianapolis General Hospital, and was resident in general surgery for two years at Kennedy Veterans Hospital, Memphis.

Completing his internship at St. Joseph Infirmary, Louisville, **Dr. John Mark James** has returned to Tell City where he is now associated in general practice with his father, Dr. N. A. James. He is a graduate of the University



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of Louisville School of Medicine and spent several years in the Navy during World War II.

Dr. Herman Hepner, 1952 I. U. graduate who has just completed his internship at I. U. Medical Center, has opened an office at 101½ North Main street, Kendallville, for the general practice of medicine.

Dr. William J. Mankin has begun the practice of medicine at 2235 Wabash Avenue, Terre Haute. He received his M.D. from Indiana University School of Medicine last year and just completed his internship at General Hospital, Indianapolis.

An additional doctor has been added to the staff of Whitlatch Clinic and Hospital at Milan. **Dr. Gilbert E. Williams**, Portsmouth, Ohio, began his practice in Milan early in July. He is a graduate of the University of Cincinnati College of Medicine and interned at Cincinnati General Hospital.

A former resident of Vincennes, **Dr. John B. Anderson**, is returning there to practice general surgery in association with Dr. R. M. Anderson and Dr. S. J. Smith. He is a graduate of Washington University School of Medicine, St. Louis, and received graduate training in surgery at City Hospital, St. Louis.

Dr. Marshall H. Seat has opened an office for the general practice of medicine in Washington in the rooms formerly occupied by Dr. H. R. Schroeder, Jr., who is in service. Doctor Seat is an I. U. graduate and interned at St. Vincent's, Indianapolis.

After completing his internship at Lutheran Hospital, Fort Wayne, **Dr. Foster C. Keller**, I.U., 1952, joined Dr. S. C. Michaelis, 2156 Fairfield Avenue, Fort Wayne, in the general practice of medicine and surgery. Doctor Keller, a native of South Bend, is a World War II veteran having served 42 months with the Air Force.

PHA, Related Groups To Convene November 9-13

Late developments in disease prevention and promotion of personal and public health will be discussed at the 81st annual meeting of the American Public Health Association and annual sessions of 40 related organizations in New York City November 9-13. Meetings will be held in the Hotels Statler and New Yorker. Attendance is expected to exceed 5,000.

Highlights of the meetings will be presentation of the Sedgwick Memorial Award for distinguished service in public health on November 11 and presentation of the Lasker Awards for 1953 for outstanding contributions to medical research and public health administration on November 12.

Subject for this year's **Caleb Fiske Prize Essay** has been announced by the Trustees of the Fiske Fund of the Rhode Island Medical Society. One of the oldest medical essay competitions, the trustees offer a cash prize of \$250 for an essay on "Recent Advances in Cardiac Surgery" which must be typewritten, double spaced, and not exceed 10,000 words. Regulations may be obtained from the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

Dr. Roscoe C. Henderson, who has been in general practice for three years in Hickory, North Carolina, has opened an office for general practice at 2229 Northwestern Avenue, Indianapolis, in rooms formerly occupied by Dr. William B. Smith. Doctor Henderson is a graduate of Meharry Medical College, 1949, and served his internship at Lincoln Hospital, Durham, North Carolina. He is a member of the National Medical Association.

Dr. Floyd W. Mohler has opened an office in Columbus at 726 Seventh Street where he will limit his practice to diseases and injuries of the bones and joints. Doctor Mohler was graduated from Indiana University School of Medicine in 1944, served his internship at Methodist Hospital, Indianapolis, and formerly practiced in South Bend.

Dr. Frank J. McGue, who recently completed his internship at Indianapolis General Hospital, is now in practice in Hobart where he is associated with Dr. Warren H. Pike. Doctor McGue served as a pharmacist's mate during World War II and began his medical training upon his return. He is a graduate of I. U. School of Medicine.

Dr. Merlynn E. Borgstede, formerly of Westport, has opened an office in Cameron, South Carolina, for the general practice of medicine. He is a graduate of University of Louisville School of Medicine.

Dr. Jens W. Larsen, veteran of the Navy Medical Corps during World War II and more recently chief surgeon at Veterans Hospitals in Amarillo, Texas, and Alexandria, Louisiana, has been named to the medical staff of the VA Hospital at Fort Wayne.

Dr. A. G. Leroy, native of Alexandria, returned there July 15 opening an office at 310

North Harrison street for the general practice of medicine. Doctor LeRoy is a graduate of Stritch School of Medicine of Loyola University, Chicago in 1951. He interned at Fitzsimmons Army Hospital, Denver, and completed his training in the Army Medical Corps.

Dr. Lyman D. Eaton, who has been in practice in Franklin has discontinued his practice there to take an extended rest after which he plans to locate in Indianapolis. His office is being taken over by Dr. C. F. Deppe and Dr. R. H. K. Foster, Franklin physicians.

Dr. Robert A. Porter became associated with his father, Dr. E. A. Porter, in the general practice of medicine in Westport on July 1. Doctor Porter spent three and one-half years in the army, two years of which were with the Third Army Hospital unit overseas. He received his medical degree from Indiana University School of Medicine.



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Society Reports

INDIANA STATE MEDICAL ASSOCIATION EXECUTIVE COMMITTEE

July 18, 1953

Roll call showed the following present: W. L. Portteus, M.D., chairman; James W. Denny, M.D.; Paul D. Crimm, M.D.; W. H. Howard, M.D.; E. R. Clarke, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump, attorney; James A. Waggener, executive secretary, and Robert J. Amick, field secretary.

Statements of receipts and expenditures and report on the budget for May and June for the Association and *THE JOURNAL* were approved.

Headquarters Office

Purchase of air conditioning equipment for the headquarters and *JOURNAL* offices was approved by consent.

Reply to the editorial appearing in *Life* magazine entitled, "Watch It, Doc," and sent to the American Medical Association upon their request, was approved upon motion of Drs. Clarke and Howard.

The field secretary reported on his activities and reviewed the report of his findings on the relationship existing between the county societies and the county departments of public welfare. The committee requested that the report be called to the attention of the Liaison Committee.

The executive secretary reported the employment of Miss Carolyn Bowman as a typist in the headquarters office, effective July 6.

Treasurer's Office

Upon motion of Drs. Howard and Denny the treasurer was instructed to invest \$60,000.00 in government bonds.

Legislative Matters

National

The secretary read the comments from the A. M. A. Secretary's Letter on H. R. 7800 and H. R. 10, the Jenkins-Keogh bill. He also reported on the item in the Secretary's Letter regarding the death of the son of Clem Whitaker, of Whitaker & Baxter, and he was instructed to write a letter to Mr. Whitaker expressing the condolences of the association.

Local

The secretary reported on the expiration of the section of the Medical Registration Law which

permitted returning physicians from military service to reinstate their licenses without the payment of penalties and delinquent fees, and informing them that a letter has been directed to the Governor of Indiana with the request as to whether any authority in the state had a right to waive this provision of the law.

1953 Annual Convention, French Lick, October 19, 20 and 21, 1953:

In discussing the program for the 1953 convention, the secretary was instructed to call attention in the program and publicity regarding the convention to all members of the association, urging them to attend the meetings of the reference committees.

A proposal for further change in the delegates' handbook was outlined by the secretary and was approved on motion of Drs. Clarke and Denny.

The secretary, by consent, was instructed to prepare an article similar to the one prepared by the American Medical Association entitled, "Your Role as a Delegate," and to insert same in *THE JOURNAL* and supply reprints to the delegates.

Final details of conducting the drawing for awarding of free rooms during the convention to those who visit all exhibits was approved by consent.

Letter from the management of the French Lick Springs Hotel regarding the \$100.00 charge for removal of furniture from the main lobby was read and approved by consent.

The secretary was instructed to buy liability insurance upon consent of the committee.

The request for opinion by the Committee on Scientific Work and the Committee on Scientific Exhibits regarding the showing of movies during the 1953 convention was discussed and turned down, on motion of Drs. Crimm and Howard.

General Practitioner Award of the Year. Upon motion of Drs. Denny and Howard, the committee voted to recommend to the Council that the requirements for the award be changed so that the award might more nearly represent an outstanding achievement by an Indiana physician during the past year. Upon motion of Drs. Howard and Crimm, it was voted to buy twelve plaques, providing the Council accepts the idea, and if so, the wording of the plaque is to be submitted to the committee for approval.

Organization Matters

Letter from Mrs. Ralph Eusden, past president of the Woman's Auxiliary to the American Medical Association, expressing her appreciation for the

courtesies shown her at the 1952 convention, was read.

Letters from Mrs. Treva Martin Smith and Miss Joan Wallace were read, expressing their thanks for the help of the association through their nursing scholarship awards.

Additional investigators for Medical Board. Letters from the Governor and the Director of the Budget were read in which they expressed regrets that additional funds could not be made available from the registration fees paid by physicians for the purpose of employing additional legal aid in the Attorney General's office for additional investigators for the Medical Board.

Letter from Dr. H. C. Ruddick, Evansville, president of the Board of Medical Registration, on this same subject, was also read.

Request of Dr. Ernest C. Murray, Kokomo, enclosing a copy of a letter directed to the State Department of Education and Vocational Rehabilitation was considered by the committee, and the secretary was instructed to call the contents of the letter to the attention of the Better Business Bureau.

Letter from DeKalb County Medical Society relative to a resolution supporting the Jenkins-Keogh bill was read, and the secretary was instructed to prepare a resolution for the DeKalb County Medical Society.

Request of Mr. Paul Cyr of the office of Secretary of State of Indiana, in which he sought permission for distribution of copies of an editorial appearing in a veteran publication entitled, "The Big Sellout," in the News Letter, was presented and discussed by Mr. Stump, who recommended that the matter be referred to the Secretary of State's office, Washington, D. C., before any action is taken by the association.

Resolution from the Indiana Department of Public Welfare regarding the establishment of a permanent liaison committee between the association and that department was read, and upon motion of Drs. Howard and Crimm this matter was referred to the House of Delegates through the Council of the association.

Indiana Public Health Association membership in the amount of \$10.00, covering the year beginning June 1, 1953 to May 31, 1954, was approved on motion of Drs. Myers and Clarke.

A gift of \$25.00 from the association toward the

purchase of a painting of the late Dr. Thurman B. Rice, to be installed in the Rice Auditorium at the State Board of Health Building, was approved on motion of Drs. Crimm and Howard.

The Journal

Report on advertising was approved by consent:

Total, June, 1952	\$2,072.10
Total, June, 1953	2,270.50
Second quarter totals: 1952	6,306.31
1953	6,461.83
July Yearbook issue: 1952	2,733.66
1953	3,449.68

Make-up of JOURNAL. The editor presented a request for permission to change the make-up of THE JOURNAL, in which the advertising would be scattered through the editorial matter, rather than bulking it in the front and back of THE JOURNAL, which was approved on motion of Drs. Howard and Crimm, with the understanding that the scientific articles would be kept together.

JOURNAL cover. The editor reported on the plans to change the cover of THE JOURNAL and reported that he had received a request from the University of Havana for a free copy of the JOURNAL, which was turned down on motion of Drs. Howard and Crimm.

New Business

Several matters were referred to the committee as a result of the recent meeting of the House of Delegates of the American Medical Association at New York in June, and these matters were passed on to the Council.

The secretary read a letter of invitation for him to appear on the program of the National Public Relations Institute at Chicago on September 2 and 3, and he was given permission to appear, upon motion of Drs. Crimm and Denny.

Permission for the field secretary to attend the Public Relations Institute was approved by consent.

Liaison committee with labor organizations. The chairman stated that he felt it would be worthwhile considering the appointment of a state liaison committee from the association to meet with labor organizations for the purpose of attempting to bring about a better understanding between the medical profession and labor organizations. Upon motion of Drs. Howard and Crimm this matter is to be referred to the Council with recommendation that such a committee be authorized and that the president appoint the members.

There being no further business, the committee adjourned to meet again at 11:00 a. m., August 30, 1953.

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

The Council of the Indiana State Medical Association convened for its summer meeting at 10:15 a.m., daylight saving time, Sunday, July 19, 1953, in the Harrison Room of the Columbia Club, Indianapolis, with Dr. Elton R. Clarke, chairman, presiding. Roll call showed the following present:

Councilors:

First District	-----Paul D. Crimm, Evansville, alternate, and president
Second District	-----A. G. Blazey, Washington Sam I. Rotman, Jasonville, alternate
Third District	-----William H. Garner, New Albany
Fourth District	-----Charles Overpeck, Greensburg
Fifth District	-----M. C. Topping, Terre Haute V. Earle Wiseman, Greencastle, alternate
Sixth District	-----W. U. Kennedy, New Castle Harry P. Ross, Richmond, alternate
Seventh District	-----Roy A. Geider, Indianapolis Don E. Wood, Indianapolis, alternate
Eighth District	-----T. R. Hayes, Muncie
Ninth District	-----Wemple Dodds, Crawfordsville H. E. Klepinger, Lafayette, alternate
Tenth District	-----J. Robert Doty, Gary James P. Vye, Gary, alternate
Eleventh District	-----Elton R. Clarke, Kokomo
Twelfth District	-----M. B. Catlett, Fort Wayne
Thirteenth District	-----Kenneth L. Olson, South Bend G. O. Larson, LaPorte, alternate

Officers:

W. Harry Howard, Hammond, president-elect
Roy V. Myers, Indianapolis, treasurer
James A. Waggener, executive secretary

The Journal:

Frank B. Ramsey, Indianapolis, editor
Stephen Johnson, Evansville, associate editor
David Bickel, South Bend, associate editor

Executive Committee:

W. L. Portteus, Franklin, chairman
James W. Denny, Indianapolis

Guests:

Cleon A. Nafe, Indianapolis, A.M.A. delegate
Clyde G. Culbertson, Indianapolis, chairman, Committee on Scientific Work
Lester D. Bibler, Indianapolis, chairman, Committee on Preceptorships
John D. VanNuys, Indianapolis, member, Committee on Preceptorships
James L. Doenges, Anderson
J. William Wright, Indianapolis; Harold C. Ochsner, Indianapolis, co-chairmen, Committee on Public Policy and Legislation
J. E. Dudding, Hope, chairman, Committee on Rural Health
Fred M. Blix, Ladoga, secretary, Montgomery County Medical Society
Mr. Albert Stump, Indianapolis, attorney
Mr. Robert J. Amick, Scottsburg, field secretary
On motion of Drs. Geider and Topping, the min-

utes of the April 25, 1953, meeting of the Council, held at Indianapolis, were approved as printed in the June, 1953, issue of THE JOURNAL.

Resignation of Dr. Catlett

Doctor Catlett read the following letter, addressed to the Council:

"I hereby resign from the Council of the Indiana State Medical Association as of this date on account of my health. Our Twelfth District will elect a new councilor."

On motion of Drs. Topping and Kennedy, the resignation was accepted, and by consent the Council went on record commending Doctor Catlett for his years of service to the State Medical Association.

Reports of Councilors

Doctor Geider announced that the fall meeting of the Seventh District Medical Society will be held on October 14 at the Indianapolis Country Club.

Doctor Dodds introduced his guest, Dr. Fred M. Blix, of Ladoga, secretary of the Montgomery County Medical Society.

Doctor Doty reported that October 14 had been set tentatively for the fall meeting of the Tenth District, pending completion of arrangements for a speaker.

Reports of Officers

Doctor Myers, treasurer, reported that upon maturity June 1 of the \$30,000.00 Certificate of Indebtedness, which bore 1 $\frac{7}{8}$ % interest, this amount was reinvested in the same type of security at 2 $\frac{5}{8}$ %, with maturity on June 1, 1954.

Doctor Ramsey, editor of THE JOURNAL: "I don't have much to report except the fact that the editorial secretary has been working for several months on plans to modernize the printing of THE JOURNAL, use of type, headings and general format, and in connection with that she is having a new cover designed. Some time this year we hope to make a complete changeover. We have already changed the type for the scientific articles, and in a few months I think we will have the whole thing changed."

Doctor Nafe, A.M.A. delegate, reported briefly on the three major actions taken at the New York meeting of the A.M.A.

(1) The A.M.A. House of Delegates reversed itself on the action taken in Denver and went on record as being opposed to any treatment of non-service connected disabilities except cases involving tuberculosis or psychiatric or neurological disorders.

(2) Recommendations of the Committee for the Study of Relations between Osteopathy and Medicine. This entire matter was deferred until June, 1954, in order that the various state associations

might have opportunity to express their opinions, at which time the A.M.A. House of Delegates should be prepared to answer the following questions:

1. Should modern osteopathy be classified as "cultist" healing?
2. Since the objectives of the American Medical Association include improvement in undergraduate and postgraduate education, should doctors of medicine teach in osteopathic schools?
3. Should the relationship of doctors of medicine to doctors of osteopathy be a matter for determination by the several state associations?

(3) *Resolutions on public criticism of physicians.* Eleven resolutions dealing with publicity regarding unethical conduct of physicians were brought before the House as a result of recent newspaper and magazine articles reporting statements attributed to an official spokesman of an allied medical organization. The reference committee to which these resolutions were referred recommended no action but reaffirmed the supremacy of the A.M.A. Code of Ethics and asked that physicians be very careful in making statements that are derogatory to the medical profession. The report read in part as follows:

"Broad generalization, ill-advised and poorly prepared statements that often fail to convey the intended meaning are most unfortunate and are to be deplored. Destructive critical comments serve no useful purpose. Your committee has the utmost confidence that the great majority of our members are entirely capable of avoiding these pitfalls without additional advice from this committee."

Unfinished Business

1. *Nominations for Editorial Board.* Dr. Doty nominated Dr. George N. Lewis, Gary (general medicine). Dr. Samuel Mercer, Fort Wayne (dermatology) was nominated at the midwinter Council meeting.

2. *Medical Education Foundation Fund.* In the absence of Dr. James W. Denny, chairman of the Committee on Medical Education and Hospitals, the secretary reported that as of July 17, 1953, the committee had forwarded approximately \$82,000.00 to this fund. According to the 1952 annual report of the Foundation, last year Indiana sent in the largest amount of money of any state in the Union. Indiana's 1952 total was \$58,152.54 from 1,217 contributors, which is included in the grand total of \$82,000.00.

3. *Present status of preceptorship plan.* Doctor Dodds, chairman of the Council Reference Committee on Educational Affairs, including Postgraduate Study and Preceptorships, to whom this matter had been referred, asked Dr. Bibler and Dr. VanNuys to speak on this subject.

Dr. Bibler reported that in May, Drs. Maurice V. Kahler, Portteus, Dudding and he had presented the preceptorship plan of the state medical asso-

ciation (published in the June, 1953, JOURNAL) to the Council of the Indiana University School of Medicine. Dr. VanNuys said the plan was very well received by the Council of the Medical School although no formal endorsement was forthcoming at that particular meeting of the Council. "In the meantime we have discussed the plan with the heads of the departments, and I am confident that it can be conducted in the Fall quarter, beginning September 15, this year, along the lines adopted by the committee, i.e., minimum of six weeks, with emphasis on general practice."

Preceptors will be screened by a committee composed of representatives of the Indiana University School of Medicine, the Indiana Academy of General Practice, and the Indiana State Medical Association. They will serve without remuneration. Only senior medical students will be eligible to take preceptorships.

In case a student working under a preceptor should become involved in a malpractice action, he would have the same protection as a student working in a hospital or a clinic. He would be working under the direction of a physician at all times, which would add extra liability to the physician who is sponsoring him.

Dr. VanNuys said that 18 or 20 letters had been received from physicians over the state volunteering to act as preceptors.

4. *Rural health.* Dr. Dudding, chairman of the Committee on Rural Health, presented the following matters for consideration of the Council:

(1) *"Medical Forums" to be carried to the county medical societies through the Rural Health Committee and the Woman's Auxiliary.* It is felt that these forums, presented at the local level, through the county societies, would reach more people than the workshops or health conferences held by the Rural Health Committee during the past couple of years. "Medical forums" have been proving successful in other parts of the country. On motion of Drs. Olson and Topping, the Council approved the "Medical Forum" plan as outlined by Dr. Dudding.

(2) *Difficulty in getting physicians to locate in rural areas due to license restrictions.* As the State Board of Medical Registration and Examination gives only one examination a year, and Indiana is one of five states which does not recognize the National Board examinations, Dr. Dudding asked if there is any way that some of Indiana's licensing regulations might be amended. Discussed by Mr. Stump and Dr. Doty.

On motion of Dr. Geider, duly seconded, This matter was referred for study to the Council Reference Committee on Educational Affairs, of which Dr. Dodds is chairman, for report at the fall meeting of the Council.

1953 Annual Convention at French Lick

Dr. Culbertson, chairman, reviewed the scientific program as arranged by his Committee on Scientific Work.

The executive secretary read a report concerning entertainment planned for French Lick from Dr. E. L. Fitzsimmons, chairman of the Committee on Convention Arrangements.

Membership Problems

Remission of state dues. Dr. Garner, chairman of the Council Reference Committee on Proposals for Remission of Dues, reported that his committee had met and had approved the remission of state dues of two Marion county members who had been certified by the county medical society secretary. On motion of Drs. Garner and Kennedy, the Council voted to remit the dues of these members.

Legislative Matters

1. *Dr. Wright*, co-chairman of the Legislative Committee, presented the following matters:

(1) *Public Law 312.* The House of Delegates, at the interim meeting in April, instructed the secretary to procure copies of this law for the Council members. The Government does not have enough copies for distribution to the Council. It was taken by consent that the secretary be excused from supplying these copies, due to the tremendous amount of work involved in making copies of this law.

(2) *Expiration July 1, 1953, of Chapter 108 of the Acts of 1951, which provided for renewal of licenses of veterans without payment of penalty and delinquent fees.* Dr. Wright reported that effort is being made to have the Attorney General provide a waiver of the penalty clauses in the interim between July 1953 and the 1955 session of the legislature, at which time legislation can be introduced validating this act.

2. *Dr. Ochsner*, co-chairman, Legislative Committee, called attention of the Council to:

(1) *Report in the June 27, 1953 A. M. A. Journal, on the meeting of the Board of Commissioners of the Joint Commission on Accreditation of Hospitals on April 19, 1953,* at which time two significant revisions in the standards of hospital accreditation were made, one of which will serve to ease the multiplicity of monthly meetings that medical staff members must attend, and the other clarifying and making more specific the organization and functions of the general practice departments in hospitals.

Dr. Ochsner said, "As you know, in the east there is a tendency toward the prohibition of general practitioners practicing in hospitals. A general practitioner must refer the hospital patient

to a specialist and from then on he is out of the picture. One wonders if Dr. Crosby (director, Joint Commission on Accreditation of Hospitals) may have something like that in mind for the whole nation. The following is part of Dr. Crosby's report:

"General Practice Departments: The standard which permits elective General Practice departments in well-departmentalized hospitals was changed to read as follows:

"A Department of General Practice shall be an organized segment of the medical staff comparable to that of other staff departments with the following limitations:

"1) The responsibilities of this department shall be limited to administration and education. It shall not be a clinical service and no patients shall be admitted to the department. If and when desirable, however, the department may be made responsible for conducting the out-patient clinic in whole or in part.

"2) Since the Department of General Practice will not have a separate service, the members of the General Practice Department shall have privileges in the clinical services of the other departments in accord with their experience and training, on recommendation of the Credentials Committee. In any service in which any general practitioner shall have privilege, he shall be subject to the rules of that service and subject to the jurisdiction of the chief of the clinical service involved."

"There is some question in the minds of some of us as to what that means to the future of general practice," Dr. Ochsner concluded.

Dr. Bibler suggested that some remonstrance be manifested through the Indiana State Medical Association objecting to this report. Discussed further by Drs. Geider, Bickel and Bibler.

On motion of Drs. Blazey and Catlett, the chairman of the Council was authorized "to appoint a committee to consider this matter and to present a resolution one way or another at the fall meeting of the Indiana State Medical Association."

Dr. Nafe's suggestion that this committee be asked "to look into the other regulations of that group" was accepted by consent.

(Following the Council meeting, Dr. Clarke referred this matter to the Council Reference Committee on Nursing and Hospital Problems, composed of Dr. Geider, chairman, Dr. Kennedy and Dr. Topping.)

(2) *Agreement concerning Indiana University School of Medicine clinicians doing private practice.* This subject was introduced by Dr. Ochsner and discussed by Drs. VanNuys, Howard, Nafe, Wright, Kennedy, Crimm and Portteus.

Dr. VanNuys presented the following plan, which was accepted by the Council on motion of Drs. Blazey and Howard "that the University be allowed a three-year trial period to operate under this plan to see how the thing works out."

Dr. VanNuys: "For many years the School of Medicine had a very limited number of so-called full-time clinicians. In 1946 this group was made up of two members of the staff of Pediatrics, one in Obstetrics and Gynecology, one in Psychiatry, and one in the Department of Internal Medicine. No definite policy had ever been stated by the School or the administration of Indiana University regarding private practice privileges for these clinicians. Three members of the staff discouraged the acceptance of private patients. The remainder developed a rather extensive private practice during the years prior to 1946.

"In planning a program of development for the School it became clear to all concerned that more full-time teachers would be needed in the principal clinical departments. This belief had the concurrence of the Association of American Medical Colleges and the Council on Medical Education and Hospitals of the American Medical Association.

"It was further generally agreed that a definite employment policy should be evolved which would clarify the position of these clinicians in relation to the acceptance of private patients.

"After an extensive study of plans operating in other schools of medicine, and numerous conferences with representatives of the local and state medical societies, a plan was presented to the Board of Trustees of Indiana University which was approved in June, 1948. This plan carried the endorsement of the medical groups mentioned heretofore. The entire plan was described in detail by Dr. Dillon Geiger in the September, 1948, issue of the Indiana State Medical JOURNAL. This plan has operated in a fairly satisfactory way, but during the past year an increasing number of criticisms has been received regarding it. A resolution drawn up by a group of the Indianapolis Medical Society condemning certain aspects of the plan was presented to the House of Delegates of the Indiana State Medical Association at the annual meeting in October, 1952. At that time the dean of the School of Medicine appeared before the reference committee of the state medical association and agreed to re-evaluate the plan in order to eliminate some of the features that were objectionable to practicing physicians. One of the objections was the requirement that clinicians report or turn in their fees to the School, and this was regarded as control practice, and in fact bordering on socialized medicine. Another objection was that the School administration could encourage men to participate to a greater degree in private practice and thereby acquire funds which could be used for purposes other than the payment of professors.

"During the past several months the School has obtained additional information on plans in operation at other schools. There appears to be a very definite trend toward employing clinicians with a guaranteed base salary, with the privilege

of seeing a limited number of patients on referral only. This is a plan which has been in operation at Harvard University and for many years at the University of Minnesota. It has recently been copied by a number of midwestern and western schools of medicine. Under this plan the dean of the school and the chairman of the clinical departments involved are pledged to see that there are no abuses. Clinicians employed on this basis would be required to attend all of their clinical conferences, their ward rounds, their classes, to continue their research, produce publications, and to attend all necessary local, state and national meetings, particularly in their specialty. It would be further agreed that the dean of the school would report to the Council of the state medical association, as requested by that body, to give statistical evidence of the operation of the plan. With approximately six years' experience under the plan approved in 1946, and with the limited facilities at the medical center for the care of private patients, it is our feeling that the new plan, as suggested, would be workable at Indiana.

"This program was presented to the Medical Advisory Council of the School of Medicine at the June, 1953, meeting. The Council authorized the dean of the School to present the program to the Board of Trustees of Indiana University and, if accepted by the trustees, to present it to the Council of the Indiana State Medical Association. The trustees of Indiana University endorsed the plan in principle at its meeting on June 13, 1953. I then requested the privilege of appearing before your group with the hope that you will give the suggestions outlined above careful consideration, and if they meet with your approval, your endorsement, at least until the time of the meeting of the House of Delegates this fall. If you find it possible to endorse this plan a call meeting of the Medical Advisory Council of the School will be held in order to gain final approval or rejection of the plan."

Dr. VanNuys thanked the members of the Council for their vote of confidence. "We shall start this plan, work diligently in it, and any time there are any deficiencies, I hope you will convey them to us. I would like to have three minutes to present to the House of Delegates at French Lick a statistical report. I want to keep the state medical association completely informed on what we are doing."

3. *Report on H. R. 10 and 11.* Dr. Blazey presented the following report which was adopted by the Council on motion of Drs. Blazey and Kennedy:

"H. R. 10 and 11 by Mr. Jenkins, Republican of Ohio, and Mr. Keogh, Democrat of New York, are identical with the revised 'Reed-Keogh' bills of the 82nd Congress which then included all amendments suggested by the A.M.A.

"The bills provide that self-employed persons not

covered by social security could deduct limited amounts of their income each year from current tax requirements in order to set up their own retirement funds under auspices of an insurance company or a trust fund. After retirement, the participants in this plan, for alleviating current tax inequities and stimulating individual initiative to take care of themselves, would pay taxes on the amount of money they withdrew from the fund each year.

"The bills provide for the deduction of 10% of their annual income, or \$7,500, whichever is smaller, with a total deduction limit of \$150,000, except that greater annual deductions could be claimed by persons between ages of 55 to 75.

"The Council Committee on Public Policy and Legislation has studied the proposed legislation and is in full agreement with same and the endorsement of the A.M.A.

"We therefore suggest that the Council of the Indiana State Medical Association recommend H. R. 10 and 11 as necessary legislation, and urge that sufficient publicity be given to the program so that our members may request their legislators to work for its enactment as a Public Law.

Committee on Public Policy and Legislation

A. G. Blazey, M.D.

W. U. Kennedy, M.D.

M. C. Topping, M.D."

4. *H. J. Res. 123.* Dr. James L. Doenges, of Anderson, discussed H. J. Resolution 123, which is a proposed "amendment to the Constitution of the United States, relative to prohibiting the United States Government from engaging in business in competition with its citizens."

On motion of Drs. Topping and Dodds, the Council voted to support this legislation and referred it to the House of Delegates.

New Business

Matters referred to Council by Executive Committee:

1. *Illinois plan for collection of American Medical Education Foundation funds.* Attention of the Council was called to a resolution which was passed at the June meeting of the American Medical Association recommending that the Illinois plan, whereby that state, by action of its House of Delegates, in 1952 and 1953 collected \$20.00 per member per year earmarked for the Medical Education Fund, be adopted by each constituent state medical association. On motion of Drs. Hayes and Garner, following discussion by Drs. Nafe, Garner, Hayes, and Blazey, the Council voted to drop this matter without action.

2. *Osteopathy situation.* Dr. Nafe explained that the delegates to the A.M.A. would like to have instructions as to how to handle "the osteopathy and the medical doctor situation. The A.M.A. calls them cults and the medical profession should not deal with cults. . . . We would like to have an expression, . . . make a canvass of our mem-

bers so that we can go back and intelligently vote next time."

Dr. Nafe read from the report of the A.M.A. Committee for the Study of Relations between Osteopathy and Medicine, as follows:

"The committee makes the following recommendations:

(1) That the House of Delegates declare so little of the original concept of osteopathy remains that it does not classify medicine as currently taught in schools of osteopathy as the teaching of 'cultist' healing.

(2) That the House of Delegates state that pursuant to the objectives and responsibilities of the American Medical Association, which are to improve the health and medical care of the American people, it is the policy of the Association to encourage improvement in undergraduate and postgraduate education of doctors of osteopathy.

(3) That the House of Delegates declare that the relationship of doctors of medicine to doctors of osteopathy is a matter for determination by the state medical associations of the several states, and that the state associations be requested to accept this responsibility.

(4) That the Committee for the Study of Relations between Osteopathy and Medicine or a similar committee be established as a continuing body."

On motion of Drs. Doty and Myers, the Council is to recommend to the Indiana House of Delegates that the word "cult" be deleted, that is, that the delegates to the A.M.A. be instructed to vote to have osteopaths not classified as cults, and that the relationship of doctors of medicine to doctors of osteopathy be determined by the House of Delegates.

3. *Collection of A.M.A. dues.* The Council discussed but took no action on:

(1) Incorporation of A.M.A. dues with state association dues in order that both state and A.M.A. dues would be paid simultaneously;

(2) Making payment of A.M.A. dues a requirement for membership in the state association;

(3) Requesting that A.M.A. dues regulations be changed so that if above requirements are adopted, the payment of dues for the current year would be sufficient for membership in good standing in the American Medical Association without the payment of any back dues.

This matter was brought to the attention of the Council as a result of a resolution introduced at the June meeting of the A.M.A. House of Delegates.

4. *Vice-president and speaker of House of Delegates.* The suggestion of the Executive Committee that consideration be given to the establishment of a vice-presidency in the association, or a speaker of the House of Delegates, or both, was rejected by the Council, on motion of Drs. Garner and Geider.

5. *General Practitioner Award.* On motion of Drs. Howard and Blazey, the Council is to formulate a policy governing the selection of the recipient of this award. (Following the Council meeting, Dr. Clarke referred this matter to the Council Reference Committee on Miscellaneous Business, composed of Dr. Kennedy, chairman, Dr. Hayes and Dr. Doty.)

6. *State Liaison Committee with Labor.* On recommendation of the Executive Committee, and on motion of Drs. Olson and Howard, the Council approved the appointment by the president of a State Liaison Committee with Labor, "to work with labor and iron out differences and policies."

7. *Request for creation of Liaison Committee with the State Department of Public Welfare.* The following resolution, adopted June 12, 1953, by the State Board of Public Welfare, at the request of the liaison committee appointed by the Executive Committee to meet with the State Department of Public Welfare, consisting of Drs. Richard P. Good, Kokomo; Russell J. Spivey, Indianapolis; E. S. Jones, Hammond, and E. L. Fitzsimmons, Evansville, was approved by the Council, on motion of Drs. Doty and Olson:

"WHEREAS, The Indiana State Medical Association, through action of its House of Delegates, has created a temporary committee of liaison on medical matters with the State Department of Public Welfare, which committee has met with the State Department of Public Welfare and has requested that we invite the Indiana State Medical Association to appoint a continuing liaison committee, and

"WHEREAS, The State Department of Public Welfare has, since the adoption of Regulation 2-111 (e)(7), urged the appointment and use of advisory and technical committees representative of the health and community interests on a county level, and

"WHEREAS, The majority of the counties in the State of Indiana have taken advantage of this regulation to create medical advisory committees to their county welfare boards, now

"THEREFORE, BE IT RESOLVED, That because of the scope of the medical programs of public welfare in the State of Indiana, the State Board of Public Welfare hereby invites the Indiana State Medical Association to create a continuing liaison committee between that organization and the State Department of Public Welfare to advise and consult with it on the medical programs of the State Department of Public Welfare."

Dr. Portteus stated that this matter should be referred to the House of Delegates at the October meeting.

8. *Recommendation of Board of Appeals on Patient-Physician Relations that a Standing Committee on Medical Court Testimony be created.* Dr. Portteus read the following letter from the Board of Appeals on Patient-Physician Relations:

"At your meeting October 5, 1952, you referred to the Board of Appeals on Patient-Physician Relations a letter from Mr. Albert Stump, legal councilor, calling the Executive Committee's attention to excerpts from the Secretary's News Letter of the Illinois State Medical Society re—

'The Physician and Medical Testimony.'

"This News Letter excerpt outlined how the Illinois Medical Society, with the cooperation and approval of the Illinois Bar Association, had established a Committee on Medical Testimony to provide controls over physicians giving false or biased testimony in the courts, etc.

"In accordance with your request, this Board has duly considered and studied Mr. Stump's communication and the subject matter attached thereto and respectfully submits the following areas of agreement and recommendations.

1. The Board agrees that Mr. Stump's communication merits serious consideration.
2. The Board agrees that the Indiana State Medical Association should provide some specific means and authority for controlling and discouraging false and unethical court testimony by physicians.
3. The Board recognizes that a liberal interpretation of its purposes and authority might include investigation of court testimony by physicians, but it is in complete agreement that its Title, Authority and Purposes as proposed by the Council and established by the 1951 House of Delegates in Amendments to the By-laws, Chapter VIII, Sections 13 and 14, and the printed rules and procedures later adopted by the Board and approved by the Council, intended to limit the Board's official actions to consideration of complaints regarding patient-physician relations.

"Therefore, the Board of Appeals on Patient-Physician Relations is reluctant to accept this additional work and responsibility without further authority from the House of Delegates and recommends that the Council either request the House of Delegates for additional authority for the Board, or recommend the establishment of a Standing Committee on Medical Court Testimony."

On motion of Drs. Howard and Hayes, the Council voted that the president appoint a separate committee "to review such cases."

No further business appearing, the Council adjourned, to meet again at 3:00 p. m., Sunday, October 18, 1953, at the French Lick Springs Hotel, French Lick, Indiana.

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Books

Books received are acknowledged in this column, and such acknowledgement must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

BOOK REVIEW

HISTOLOGY, Second Edition. By Arthur Worth Ham, M.B., Professor of Anatomy, in Charge of Histology, Faculties of Medicine and Dentistry, University of Toronto, Toronto, Canada. Price \$10.00. J. B. Lippincott Company, East Washington Square, Philadelphia 5, Pa. 1953.

This book consists of 850 pages divided into 30 chapters, is well organized and beautifully illustrated. The author begins with a general introduction and historical notes and follows with ordinary and special histological methods and gives some very valuable notes on both study and interpretation of sections. There is an excellent chapter on cytology, including most of the up-to-date information on the fine structure of cells and the relation of structure to function. The author shows great ability in presenting material very clearly without oversimplification. The extensive illustrations are of superb quality and are chosen well for the purpose intended. The chapters are divided into headings and subheadings and the print is large and easily readable. The author establishes excellent "liaison" between morphological histology and the related subjects of embryology, physiology, bio-chemistry, and pathology. The excellent bibliographies at the end of each chapter are particularly valuable.

In the reviewer's opinion, the book leaves little to be desired and is one of the really fine books of the present period.

C. G. C.

MICROBIOLOGY AND PATHOLOGY. By Charles F. Carter, M.D., director, Carter's Clinical Laboratory, Dallas, Texas, and Alice L. Smith, M.D., instructor in microbiology and pathology, Parkland Hospital School of Nursing, Dallas, and assistant professor of pathology, Southwestern Medical College of University of Texas. 5th edition. 847 pp. with 260 illustrations. Price \$5.50. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Missouri. 1953.

CHILD DEVELOPMENT. By William E. Martin and Celia Burns Stendler, Professors of Education, University of Illinois. 519 pp., illustrated. Price \$6.50. Harcourt, Brace and Company, 383 Madison Avenue, New York 17, N. Y. 1953.

ENCYCLOPEDIA OF ABERRATIONS. Edited by Edward Podolsky, M.D., State University of New York Medical College. 550 pp., illustrated. Price \$10.00. Philosophical Library, Inc., 15 East 40th Street, New York. 1953.

PHEOCHROMOCYTOMA and the GENERAL PRACTITIONER. By Joseph L. DeCourcy, M.D. and Cornelius B. DeCourcy, M.D., DeCourcy Clinic, Cincinnati 2, Ohio. 165 pp. Copyrighted by Barclay Newnan.

HISTOLOGY, Second edition. By Arthur Worth Ham, M.D., professor of anatomy, in charge of histology, faculties of Medicine and Dentistry,

University of Toronto, Toronto, Canada. 866 pp., 518 Fig. numbers, 7 color plates. Price \$10.00. The J. B. Lippincott Company, East Washington Square, Philadelphia 5, Pa. 1953.

CHILDREN OF DIVORCE. J. Louise Despert, M.D., child psychiatrist with Cornell University 15 years, now associate professor of Clinical Psychiatry. 282 pp. Many case studies. Price \$3.50. Doubleday & Company, Inc., 575 Madison Avenue, New York 22, N. Y. 1953.

THE PHYSICIAN IN ATOMIC DEFENSE. Thad P. Sears, M.D., associate clinical professor of medicine, University of Colorado School of Medicine. 308 pp., illustrated. Price \$6.00. Year Book Publishers, Inc., 200 E. Illinois Street, Chicago 11, Ill. 1953.

THE EPIDEMIOLOGY OF HEALTH. A New York Academy of Medicine Book edited by Iago Galdston, M.D. 197 pp. Price \$4.00. Health Education Council, 10 Downing Street, New York 14, N. Y. 1953.

MODERN CONCEPTS IN MEDICINE. By Julius Jensen, Ph.D. (in Medicine), University of Minnesota; M.R.C.S., England. 636 pp., illustrated. Price \$11.50. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Mo. 1953.

MECHANISMS OF UROLOGIC DISEASE. By David M. Davis, M.D., professor of urology emeritus, Jefferson Medical School and visiting lecturer in urology, Graduate School of Medicine, University of Pennsylvania. 156 pp. W. B. Saunders Company, West Washington Square, Philadelphia, Pa. 1953.

LOCAL SOCIETY REPORTS

"The Herniated Intervertebral Disc" was the title of the paper presented by Dr. E. Vernon Hahn, Indianapolis, to members of the **Montgomery County Medical Society** on June 18. The dinner-meeting, which was the last planned until September 17, was held in the Culver Union Hospital, Crawfordsville, with 23 members present. A brief business meeting was held.

Six members of the **White County Medical Society** met July 14 for a business meeting. Plans were made at that time for the next meeting of the group which will be held in Monticello October 13.

Washington County Medical Society members held a meeting July 14 with seven doctors attending the combined society and hospital staff meeting in Washington County Memorial Hospital, Salem. Dr. William T. Paynter, who is practicing in Pekin, was welcomed as a new member of both society and staff.

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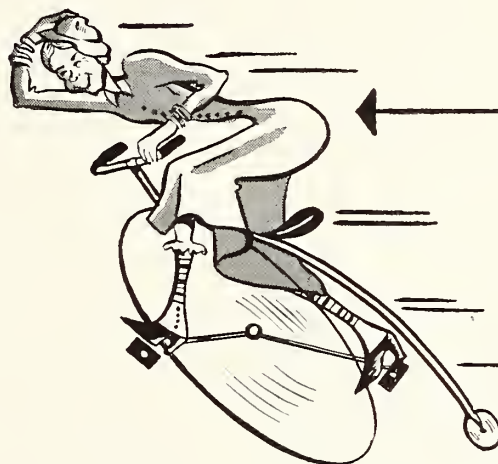
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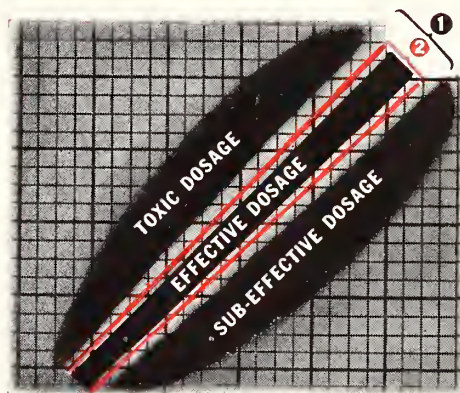
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SINGING the "old St. Louie blues" again . . . physicians and AMA staff members are completing arrangements for the seventh annual Clinical Session December 1-4 in St. Louis. This year's program has been designed to give the general practitioner an opportunity to see and hear the latest developments in medicine. A brief glance at the scientific program indicates that some outstanding features have been lined up to cover the newest techniques in medical practice. Such topics as chest injuries, compression fractures of the vertebra, chronic pancreatitis, weed poisoning and chronic arthritis—drugs and vaccine therapy, will be presented. Special features include—*fracture* demonstrations; *problems of delivery*, manikin demonstrations by leading obstetricians; *traffic accidents*, an exhibit symposium combining the experiences of physicians, the National Safety Council and police departments, and stressing the responsibility of the physician in the prevention of such

accidents, and *diabetes*, which includes exhibits and question-and-answer conferences in an adjoining room.

The Jefferson Hotel has been selected as the headquarters for House of Delegates sessions and Reference Committee meetings. All other features—Scientific Exhibit, lectures, motion pictures, color television, Technical Exhibit—will be presented at the Kiel Auditorium. More than 80 exhibits, with continuous demonstrations and plenty of time for personal consultation, will make up the Scientific Exhibit. The Technical Exhibit will feature approximately 150 displays covering all types of office and medical practice needs.

Plan now, doctor, to attend this worthwhile medical meeting!

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BOOK REVIEW

CONDUCTION ANESTHESIA—Second edition. Edited by James L. Southworth, M.D., F.A.C.S.; Robert A. Hingson, M.D., F.A.C.A., F.I.C.A., F.I.C.S.; Winifred M. Pitkin, M.D., M.R.C.S. (England) Cloth binding, 949 pp. exclusive of bibliography with 585 illustrations. J. B. Lippincott Company, East Washington Square, Philadelphia 5, Pa. 1953.

A remarkable work on conduction anesthesia in its first edition, improved and brought up-to-date and simplified in its presentation. New local anesthetic agents, more efficient vasopressors and new apparatus have contributed to the need for a new edition in this expanding field of medicine.

The addition of the final chapter on complications of conduction anesthesia is invaluable. The six chapters on the anatomy of the nervous system with the clear cut illustrations are concise and give a necessary review of the salient anatomical points. The chapter heading break-down makes for easy reference for the busy practitioner.

The chapter on conduction anesthesia of the extremities gives an easily followed technique for those physicians, who must by circumstances, work both as surgeons and anesthetists. More emphasis is placed on therapeutic conduction anesthesia. The chapter on spinal anesthesia, especially applied to the obstetrical field, should appeal to the general practitioner as well as the surgeon because of its simplicity.

W.L.P.

BOOKS RECEIVED

Books received are acknowledged in this column, and such acknowledgement must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

THERAPEUTICS IN INTERNAL MEDICINE. By 84 authorities, edited by Franklin A. Kyser, M.D., assistant professor of medicine, Northwestern University Medical School, Chicago. Second edition, revised and reset. 830 pp. Price \$15.00. A Hoeber-Harper book. Paul B. Hoeber, Inc., Medical Book Dept. of Harper & Brothers, 49 East 33rd St., New York 16, N. Y. 1953.

NERVOUS SYSTEM. Frank H. Netter, M.D., First of a series planned by Ciba Pharmaceutical Products, Inc., portraying anatomy and pathology of all the systems of the human organism. 143 pp., with 104 illustrations. Price \$6.00 (cost). Publications Dept., Ciba Pharmaceutical Products, Inc., Summit, New Jersey. 1953.

THE CONCEPTION OF DISEASE. By Walther Riese, M.D., member of staff of Medical College of Virginia. 120 pp. Philosophical Library, 15 East 40th St., New York 16, N. Y. 1953.

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Books

ENDOCRINE TREATMENT IN GENERAL PRACTICE. Edited by Max A. Goldzieher, M.D., Endocrinologist, St. Clare's Hospital and Consultant Endocrinologist, Goldwater Memorial Hospital, New York; and Joseph W. Goldzieher, M.D., Research Associate, New York Medical College, and Director of Research Laboratories and Assistant Physician, St. Clare's Hospital, New York. Cloth. 474 pages with 16 figures. 1953, Springer Publishing Company, Inc., 44 East 23rd Street, New York 10, New York. Price \$8.00.

Twenty-one contributors representing nationwide clinical experiences are the authors of this book.

Treatment is emphasized.

Recognizing the tremendous tangle of concepts that beclouds the average physician's mind when it contemplates endocrine disorders and the multitude of uses and abuses to which hormones have been put as therapy, the authors reasoned that there should be a practical guide book, less complex than the usual text in endocrinology, which would be suitable for the general practitioner. Their aim was to help the latter arrive at more definitive diagnoses, discuss with him as consultants the practical treatment course to follow, and more specifically to recommend the hormone preparations, doses, and methods of application that have proved effective in their own clinical practices. They state results to be expected, necessary cautions, and side effects of treatment to guard against.

The last section of this book lists hormone preparations currently available.

In presenting the various aspects of metabolic disturbances the material is arranged according to localization of presenting symptoms as well as to types of endocrinopathies. Therapy is discussed not only where deficiency exists but also in those disease conditions where no specific deficiency has been shown but in which hormone therapy has proven beneficial. In this respect ACTH and cortisone have led the way in treating a wide field of nonendocrine conditions and have stimulated interest in possible uses for other hormones, natural or synthetic, as pharmacological agents.

The book is conveniently arranged in sections for easy reference: Disorder of age and growth, metabolism and nutrition, organ systems, resistance and neoplastic diseases. Each contains chapters that are concise, factual and straightforward. The authors speak as if they were at the bedside acting as consultants.

Bibliographical references are deleted from this book. It is completely indexed.

T.M.C.

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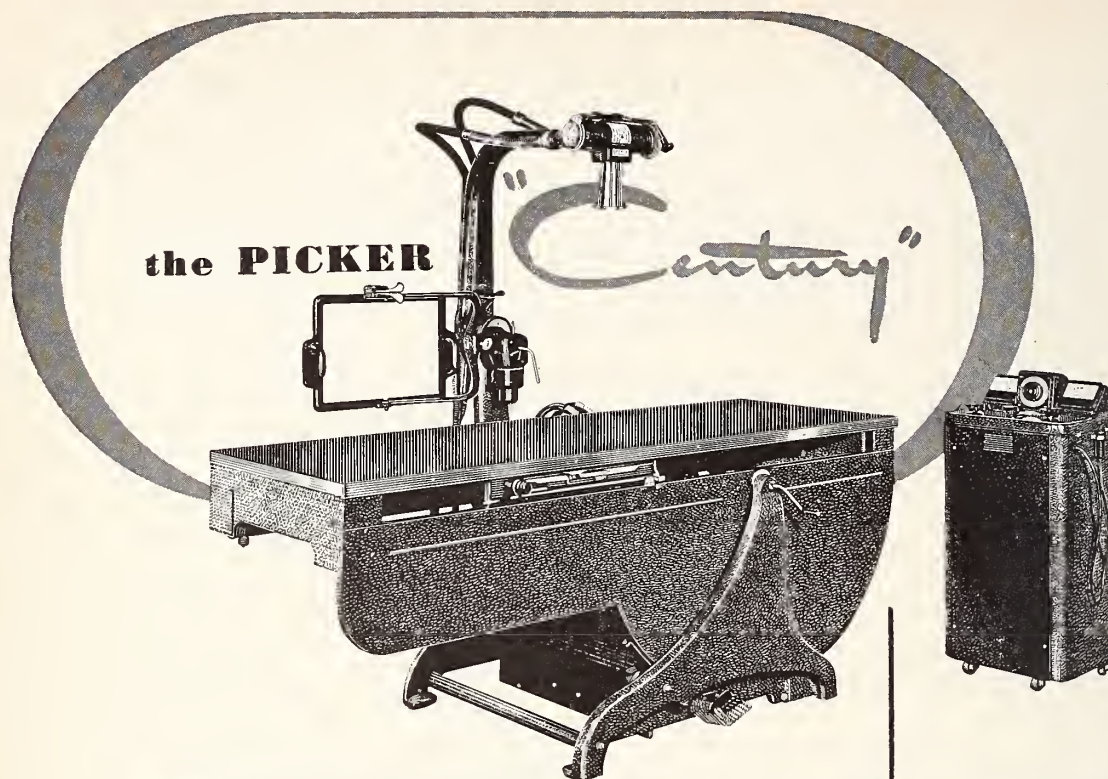
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William G. Thomas, M.D. 218 South Lincoln Street Hinsdale, Illinois	General Practice
Robert L. Reschke, M.D. 11546 South Princeton Chicago 28, Illinois	General Practice
Robin Smith, M.D. 104 North Commercial Street Neenah, Wisconsin	Pediatrics
M. H. McCoy, M.D. General Hospital Indianapolis 7, Indiana (Available July, 1954)	General Practice
William A. Decker, M.D. 4214 West Michigan Kalamazoo, Michigan	Associate in G. P.
William H. Davis, M.D. New Market, Indiana	General Practice

(Continued on Page 950)

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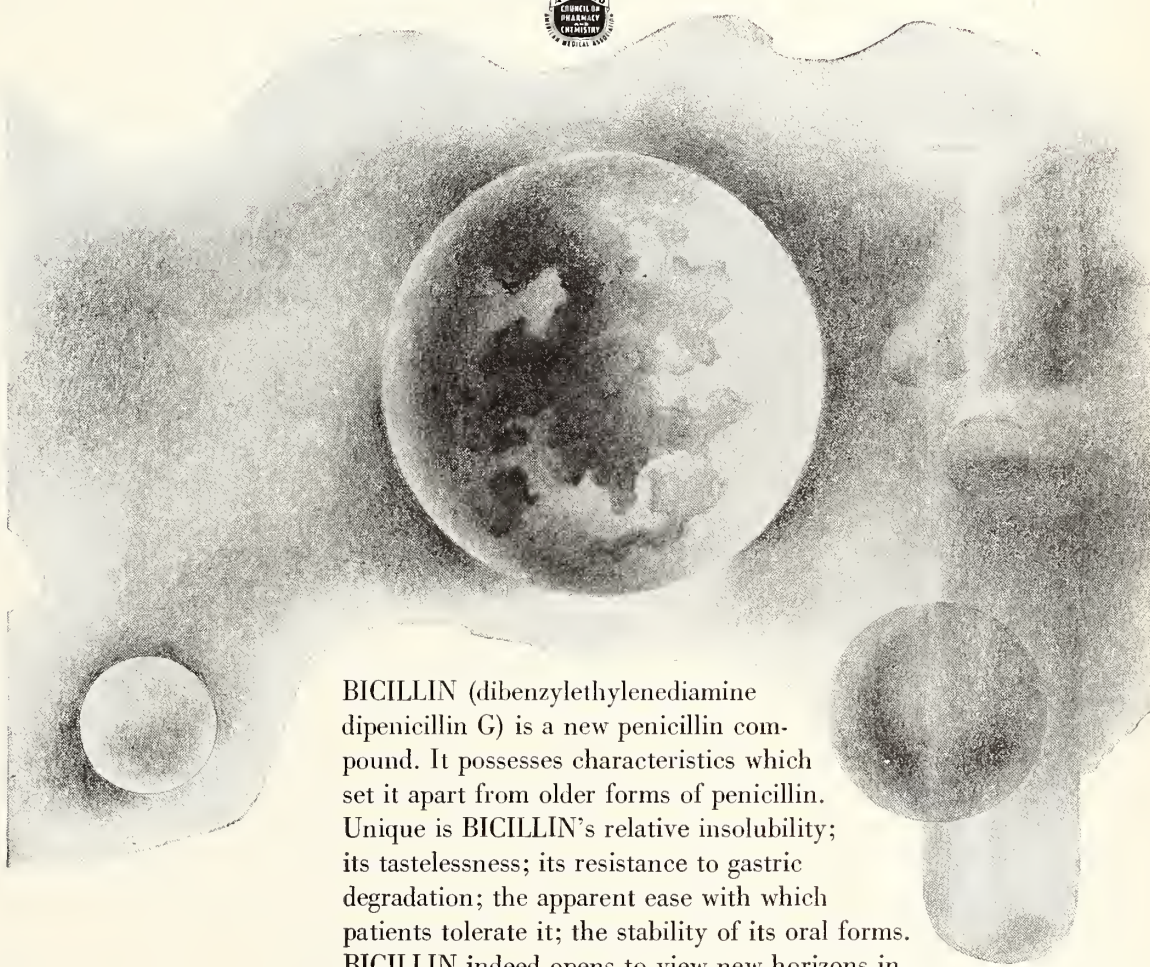
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Guilford	Dearborn	250	Mrs. Floyd Cook, R. 1, Lawrenceburg
Covington	Fountain	2,235	Mrs. J. W. Aldridge
Brookville	Franklin	2,194	Mrs. R. E. Glaser
Owensville	Gibson	1,200	B. W. Johnson, D.D.S.
Lyons	Greene	800	Dr. M. W. Manzie, General Hospital, Indianapolis
Sheridan	Hamilton	1,720	Dr. John L. Reck
Elizabeth	Harrison	250	Mrs. Minnie Bierly
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Sandborn	Knox	602	Mrs. D. J. Schaaf, 2151 Bayard Drive, Evansville, Ind.
Vincennes	Knox	18,228	Dr. Maurice Fox, 616 Shelby St.
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Mooreville	Morgan	2,000	J. M. Stanley, 493 E. Mill, Danville, Ind.
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Hamilton	Steuben	392	Dr. J. A. Alford
Windfall	Tipton	835	Sidney Legg
Newburgh	Warrick	1,375	Dr. I. L. Faith
Dublin	Wayne	750	Dr. Wm. H. Zimmerman
Versailles	Ripley	582	Dr. L. H. Hopkins
South Whitley	Whitley	1,200	Mrs. Paul Garber

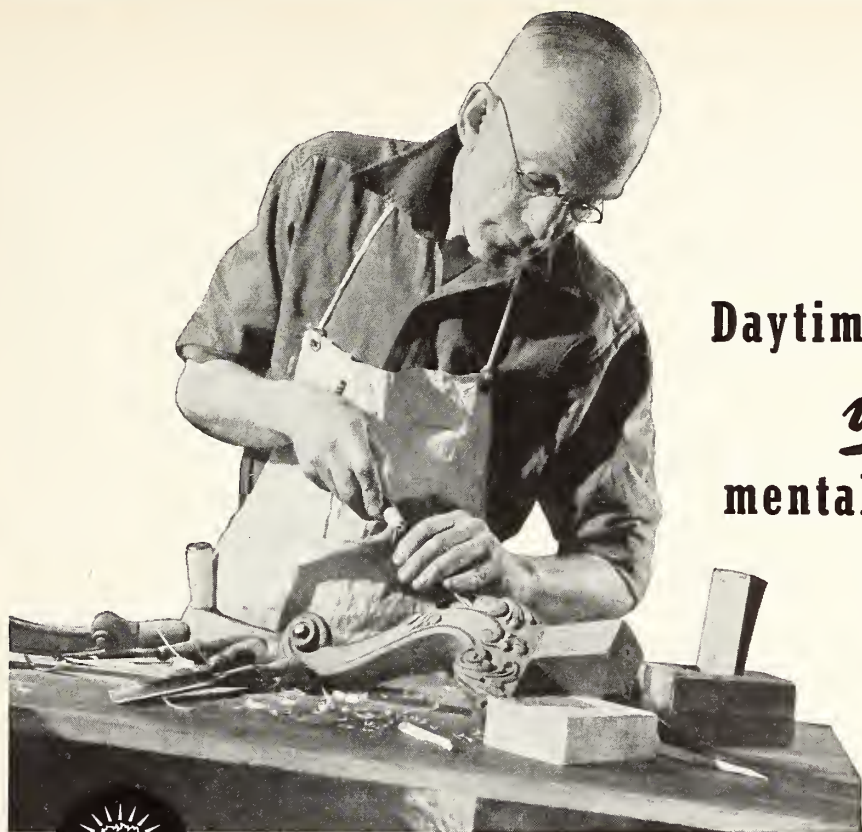
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Medical-Dental Management

Ford Hospital Sponsors Virus Infection Symposium

"The Dynamics of Virus Infection" will be the subject of an international symposium to be held in Henry Ford Hospital, Detroit, on October 21-23 under the auspices of the hospital. Advisory members of the program committee include Thomas Francis, Jr., professor of epidemiology, University of Michigan; John G. Kidd, professor of pathology, Cornell University College of Medicine; Joseph E. Smadel, chief, Department of Virus and Rickettsial Diseases, Army Medical Service Graduate School, Washington, D. C.; and Frederick D. Stimpert, director, microbiological research, Parke Davis & Company, Detroit. An imposing group of speakers will participate including authorities from Australia, Denmark, England, and Malaya. The majority of the speakers are well-known U. S. physicians and research scientists.

Indiana doctors are welcome to attend, Edward L. Quinn, secretary, announces.

Thanks to the Doctor . . .

this old world of ours is constantly being made happier and healthier.

Whenever we advise a person to see his or her physician, we feel that we have performed a service which is a part of our obligation to humanity.



Opinions From Here and There

Prepared for your information by the Committee on Public Policy and
Legislation of the Indiana State Medical Association

AN IMPORTANT EVENT—PASSED UNNOTICED, September 17 was a date which should have received recognition from every red blooded American, as it has vital significance for every person in America. Nobody celebrates it, and practically nobody is aware that it is the anniversary of the Signing of the Constitution of the United States—a document we are very prone to take for granted. “We the People” have built our lives upon this foundation, a plan, clear and simple, with its principles stated in the Preamble.

“WE THE PEOPLE OF THE UNITED STATES, in order to form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common defense, promote the General Welfare, and secure the Blessings of Liberty to ourselves and our Posterity, do ordain and establish the Constitution of the United States of America.”

THE MEN WHO REPRESENT US, the members of Congress are at home. Why not plan to talk to *your* Congressman during his vacation about legislative problems? Why not plan to invite him to be a guest at your medical society meeting for a discussion of legislative problems of interest to the profession? They are your representatives, they are the ones who are interested in your opinions, and they are the ones to explain to you what's going on in your government.

BEFORE HE LEFT TOWN, AFTER CONGRESS ADJOURNED, writes Frank Wilson, director of the AMA's Washington Office, a Senator who is a friend of mine (and of the A.M.A.) made this suggestion: “Why don't the doctors, once in a while, invite us to their meetings when we're home? Most of the time we'd be willing to talk to them about Washington and what we're doing, but I'm thinking more of just meeting them, saying hello, and answering their questions.” Here's a tip worth heeding.

A POSER FOR YOU—and we quote from a bulletin distributed to members of another association. “For some weeks now, economic service publications, trade magazines and the like have been referring to the political activities of two leading labor organizations—CIO and A. F. of L.—in preparing to influence legislation in the coming session of Congress and in the election next year. Their leaders are buttonholing members of Congress demanding action on social welfare laws, including federal housing, socialized medicine, federal aid to education, etc., etc., etc.”

STRANGELY ENOUGH, BUSINESS MEN are doing nothing that approaches the program of labor. (That includes medicine, too). As a result members of Congress, your own representatives, are wondering, “Just how do you feel about taxes, the farm program, an expansion of the social welfare program, the Taft-Hartley law, foreign affairs, etc?”

A PERSONAL TALK IS BETTER THAN a letter they receive when Congress is in session. In presenting your opinions don't berate the labor groups for they are only doing what business and professional men should be doing under the circumstances.

YOU GET SO MUCH—FOR SO LITTLE! AMA dues, the \$25 you pay, go to make up a portion of the income of the American Medical Association.

The approximate balance sheet of the AMA shows:

ASSETS

Association dues	\$3,420,000.00
Subscription to Journals	1,710,000.00
Journal Advertising	2,700,000.00
Investments & Misc. Income	1,170,000.00
	<hr/>
	\$9,000,000.00

DISBURSEMENTS

Scientific Exhibits	\$4,860,000.00
Socio-economic activities	450,000.00
Public Relations	2,070,000.00
Advertising Cost	630,000.00
State Journal Advertising	720,000.00
Legislative Activities	270,000.00
	<hr/>
	\$9,000,000.00

THE ABOVE FIGURES PLACE THE "Huge Political Lobby" and its cost way at the bottom of a long list of activities, the most important of which is outlined in Article "a" of the Constitution. "The objects of the Association are to promote the science and art of medicine, and the betterment of public health."

UAW-CIO REPORTS NET WORTH OF \$17,451,658.07 as of June 30, 1953, stating this represents a gain of \$5,412,360.78 over their May 31, 1952 figure.

1,429,827 IS THE FIGURE LISTED as dues paying members of this organization, on an average during the first eight months of 1953.

WHILE NO FIGURES ARE QUOTED for the money received and spent by the UAW-CIO Political Action Committee in the published report, it can be remembered when the PAC was asking for a minimum of a dollar from each member for the purpose of financing the legislative work of the union. If they were successful in getting just a dollar a year they would have received \$1,429,827.00, and if it was a dollar a month they asked for, you can multiply the above figure by 12 and come up with \$17,057,924.00. Even the one dollar per year figure dwarfs the AMA Legislative figure, so if Medicine is operating the biggest lobby in Washington, the Union Lobby

is indescribable in size, on the basis of probable money received and spent for this purpose.

HOBBY HEALTH HINTS KEEP AMA ON RUGGED DEFENSIVE. Secretary Oveta Culp Hobby's address before American Hospital Association in San Francisco, a few weeks ago, was reminiscent of an Oscar Ewing speech of the Truman era. It elicited a strong response by AMA which some feel betrayed a wistful disappointment that a high placed lieutenant in the new administration should be impelled to say something should be done to help the middle-income people meet the high cost of medical and hospital cost. The statement by AMA President Edward J. McCormick was as meticulous in commenting specifically on Mrs. Hobby's medico-economic remarks as it was in refraining from mentioning her by name, so says the Washington Report on Medical Sciences.

THE SOURCE REPORTS THE FOLLOWING EXCERPTS: Mrs. Hobby—"We have not yet found a way to save any average American family from destruction by the catastrophic illness."

Dr. McCormick—"It is unnecessary to suffer catastrophic financial loss" (with reference to three specific cases described by Mrs. Hobby). "It need never occur."

Mrs. Hobby—"More is needed, and we must find the way to achieve that more within our private enterprise system."

Dr. McCormick—"AMA has been working on this problem for years and we think it is being solved. Certainly there is no need for government action."

Mrs. Hobby—"Tuberculosis, poliomyelitis, strokes, congenital defects, cancer, arthritis and many other diseases by their very duration can still wreck many a family's economy."

Dr. McCormick—"The incidence of tuberculosis is falling rapidly to the point of negligibility. We seem to be on the verge of finding a preventative for at least some types of poliomyelitis and some doctors think we will soon have a curative agent for some cancers."

DOCTOR SHORTAGE STRESSED by Secretary Hobby when she emphasized the shortage of physicians. "Our doctor shortage looks non-existent at first glance, but we should not delude ourselves . . . we need to face the fact that we need more doctors of all kinds." Speaking in Louisville, Kentucky at the corner stone laying of the new Jewish Hospital, she repeated her warning that the training of physicians is not keeping pace with population increases.

ANOTHER EXAMPLE OF HOW YOU CHOOSE YOUR FIGURES since the figures released this year on the training of physicians shows that the number of physicians trained exceeds the increase in population, percentage-wise.

FDIC HEALTH PLAN NEARS FIRST BIRTHDAY LUSTILY. Nearing completion of its first year of operation is Washington's unique health insurance program. This is the medical care and hospitalization plan covering nearly

1,000 employees of Federal Deposit Insurance Corporation. A few words on its progress may be in order, since it is quite probable that the FDIC experiment will give impetus to legislation now pending in Congress to increase membership of Federal employees in voluntary prepayment health plans. As a practical demonstration, it may even influence anticipated legislation dealing with provision of care for dependents of servicemen.

Summed up, FDIC's plan is working out splendidly—96 per cent of personnel covered; complaints by subscribers extremely few; liberal-benefit coverage an important inducement in recruitment of personnel; administrative complications fewer than expected.

NEW CONTRACT DISCUSSED. FDIC's contract with Health Service, Inc., a subsidiary of Blue Cross Association, will expire on November 1. Negotiations looking toward renewal are getting under way. A self-supporting organization which, receiving no appropriations from Congress, is empowered to introduce an employee service of this kind without special legislation, FDIC pays the \$3.11 monthly premium for each unmarried employee. For the other two types of enrollment—two-person and family—the employee's contribution is \$3.59 and \$5.27, respectively. As of September 1, 968 of the Corporation's slightly more than 1,000 personnel were covered: 458 as individuals, 153 with two-person certificates and 357 on a family basis.

Fewer than 10 eligibles have chosen not to participate. To date only one enrollee has dropped his membership, this case being attributable to complications that arose when his wife, working in another city, joined a prepayment plan. Some 30 to 40 other employees are awaiting end of 90-day waiting periods to enroll.

EXTRA SURGICAL FEES FEW. At program's outset last November, there was a bit of trepidation that supplemental medical bills would be a problem. (Surgery maximum is \$250 and in-hospital medical visits are fixed at \$4, but the physician may bill the patient for sums in excess of these fee-schedule rates). However, there have been comparatively few complaints on this score, according to Floyd E. Tift, personnel director of FDIC. The contract's provision that medical services may be performed by any duly licensed physician has worked out advantageously by broadening the patient's free choice of doctor to include practitioners of osteopathy, Tift explained.

SURVEY NOTES GAINS IN NON-VOLUNTARY COVERAGE. Findings of a survey published last week by U. S. Chamber of Commerce disclose appreciable gains in 1952 by companies writing medical, surgical and hospital care insurance. Among the figures, which do not include membership in voluntary plans or enrollment through group insurance, are the following:

At the close of 1952, 10,090,000 policy holders and their 12,164,000 dependents had protection against hospital expenses—3 per cent gain; surgical expense insurance was carried by 19,196,000, including 11,486,000 dependents—17 per cent gain; medical coverage was held by 2,411,000 and their 2,709,000 dependents—21 per cent gain. Smallest increase was in insurance against income loss due to illness or accident, from 12.5 million in 1951 to 12.6 million in 1952.

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THE SURGICAL MANAGEMENT OF THE SEQUELLAE OF ACUTE PANCREATITIS

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ACUTE PANCREATITIS as the cause for abdominal pain is being considered more often now than in former years, and the clinical diagnosis is being confirmed by either the blood amylase test or by direct inspection of the gland if surgical exploration is done. The inflammatory process may leave certain residuals which are of surgical interest and which may require surgical therapy. The two most common are pancreatic abscess and pancreatic cyst. This paper is being written to call attention to the possibility of these two lesions occurring after an attack of acute pancreatitis, and to discuss certain features of their management.

It has been stated that about 15 to 20 percent of patients who have acute pancreatitis will develop either an abscess or a cyst¹. Since the inflammatory process is more intense and tissue destruction greater in the hemorrhagic form, cyst and abscess are more often seen following this type. It is difficult, if not impossible, to differentiate between the edematous and hemorrhagic forms by clinical means. Indeed, it is possible that the latter may be merely a more severe form of the disease. Until the exact

etiology is better understood this point will remain in doubt.

One of the most widely accepted theories for the cause of acute pancreatitis is that of the reflux of bile up the pancreatic duct; the bile activating the pancreatic ferments with resultant inflammation of the gland. This results in edema and swelling of the gland, with some necrosis of the adjacent fatty tissue. In some instances, the same, or a very similar inflammatory process is associated with hemorrhage and pressure necrosis producing the anatomical picture clinically designated as acute hemorrhagic pancreatitis. Large areas of the gland may become liquefied, forming a pseudocyst which contains hemorrhagic fluid, cellular debris, and perhaps pancreatic enzymes. These cysts may occupy any part of the gland and their anatomical location will determine to a great extent the physical findings. That is: cysts of the body of the gland, for instance, tend to protrude through the gastrocolic ligament and present in the left hypochondrium.

If the chemical inflammation in the gland becomes associated with a bacterial one an abscess may form. This may be quite large, and may rupture into adjacent viscera, or burrow retroperitoneally and present in the flank.

*From the Surgical Service of the Welborn Clinic and the Welborn Memorial Baptist Hospital.

Acute pancreatitis usually starts with rather abrupt epigastric pain which is severe, and which may radiate out over the entire abdomen. The intensity of the pain is comparable to that of a perforated duodenal ulcer, severe biliary colic, or a strangulating type of small bowel obstruction. The blood pressure has been reported as being elevated and cardiac arrhythmia as being common, possibly due to retroperitoneal irritation of the sympathetic ganglia. The condition may be confused with coronary occlusion, biliary colic, or with other painful abdominal lesions, but can be differentiated by means of the blood amylase test. Elevations of the serum amylase are considered highly diagnostic, but the test must be done early in the course of the illness; otherwise the amylase level may have returned to normal.

Patients having an acute attack of pancreatitis may some weeks later note a rather painless swelling in the upper abdomen. Clinical examination will reveal a rounded, smooth, only slightly tender fixed mass, which will appear firmer to the examining hand than one thinks a cyst should feel. This firmness is due to thickening of the cyst wall brought about by edema and inflammation. These findings are characteristic of pancreatic pseudocyst. Abscess formation may occur rather early in the course of acute pancreatitis, and is indicated by fever, abdominal tenderness, and perhaps an upper abdominal mass. The abscess may appear somewhat late in the course of the illness, and, in such instances, the signs of inflammation may be minimal, making it impossible to exclude a pseudocyst. The mucosa of the organs adjacent to the abscess, notably the stomach, becomes congested, erosions may occur with consequent bleeding and hematemesis. Occasionally spontaneous rupture of the abscess occurs into neighboring hollow viscera. A pseudocyst may also fill and rupture intermittently with a disappearance of the mass for a time, only to recur as the cyst fills again.

The treatment of pancreatic abscess, as with that of abscess elsewhere, is one of incision and adequate drainage. This is a major surgical undertaking to be carried out under good relaxing anesthesia, with sufficient assistants to provide the proper exposure of the area under investigation. The inflammatory process is intense, there are usually large areas of fat

necrosis, and these changes may make identification of the local organs difficult. Great care must be exercised not to enter the transverse colon or the stomach, nor to injure the duodenum or superior mesenteric vessels. If the abscess presents through the gastrocolic ligament this structure may be opened, the colon rotated inferiorly, and the thickened wall of the abscess entered under direct vision; the pus being removed by suction. In order to provide adequate, continuing drainage, the wall of the abscess cavity can be sutured to the parietal peritoneum, multiple drains inserted, and the incision closed with through and through steel wire sutures. Upper transverse abdominal incisions give good exposure, are perhaps stronger than vertical ones in this area, and lend themselves well to the treatment of this lesion. The abscess cavity can be kept empty by continuous aspiration and irrigation until healing occurs.

Pancreatic pseudocysts have been treated in various ways; perhaps the most common being that of marsupialization. Since they are most commonly caused by inflammation, they are densely adherent to adjacent structures, making it difficult, if not impossible to excise them. In recent years many of them have been treated by anastomosis in continuity to adjacent organs, such as the stomach or jejunum. In general, this seems to have been a satisfactory method of treatment, although it is said to have the disadvantage of possibly permitting food particles to enter the cyst cavity. To obviate this, defunctionalized loops of jejunum embracing the Roux-Y principle recently have been advocated. The first such successful case to be reported was that of Gurwitz² in 1948. Figure 1 is the artist's conception of this technic which was used in our case No. 1. The gastrocolic ligament has been opened to expose the cyst, the jejunum has been divided about 60 or 70 cms., distal to the ligament of Treitz, and the oral end connected to the intestine by means of an end to side anastomosis; the end of the aboral segment being drawn through a rent in the transverse mesocolon and sutured to the side of the cyst. Such an arrangement defunctionalizes this loop of bowel and prevents reflux of intestinal content into the cyst, but permits it to empty itself. In order to have prevented possible stenosis or stricture of the ostium it might have been wiser to have obtained a wider pri-

mary opening by suturing the side of the jejunum to the side of the cyst.

Report of Cases

Case No. 1. (W.M.B.H., D-6006)—Mrs. B. M., a 48 year old white female was seen in July 1951, complaining of cramping upper abdominal pain, which later seemed to localize in the left lower abdominal quadrant, and which was associated with moderate abdominal distention and tenderness. The blood amylase level was 325 mgs. per cent. She had a rather severe paralytic ileus, vomited bile stained fluid, had a low grade fever, but finally recovered and left the hospital after about ten days. She felt fairly well until June 1952, did not have colic or jaundice, but complained of some nausea and of recently having noted a mass in the left upper abdomen. This did not move on inspiration and felt more solid than cystic. The blood amylase was 109 mgs. per cent, the urine free of sugar and otherwise normal. Radiographic examination of the gallbladder revealed poor visualization with a question of mottling. Fluoroscopic and radiographic examination of the gastrointestinal tract showed an extrinsic pressure defect on the lesser curvature of the stomach with superior displacement of the splenic flexure of the colon. Surgical exploration revealed a large, benign pseudocyst in the body of the pancreas presenting primarily through the gastrohepatic ligament. The gallbladder contained a few small stones. Internal drainage was elected and carried out as illustrated in Figure 1. The patient's post-operative course was good and she was discharged on the thirteenth day with instructions to have cholecystectomy at a convenient interval time. She has remained asymptomatic.

Case No. 2. (W.M.B.H., D-5608)—Mr. J. K., a 65 year old white male suddenly had continuous epigastric pain on April 29, 1952. His physician thought he had biliary colic. He was hospitalized; he vomited frequently, the vomitus occasionally containing old blood. X-rays were carried out and a diagnosis of duodenal ulcer with obstruction was made. He continued to have aching upper abdominal pain with fever, and was seen by us during the sixth week of his illness.

The physical examination revealed a very ill, febrile, 68 year old, obese man with somewhat

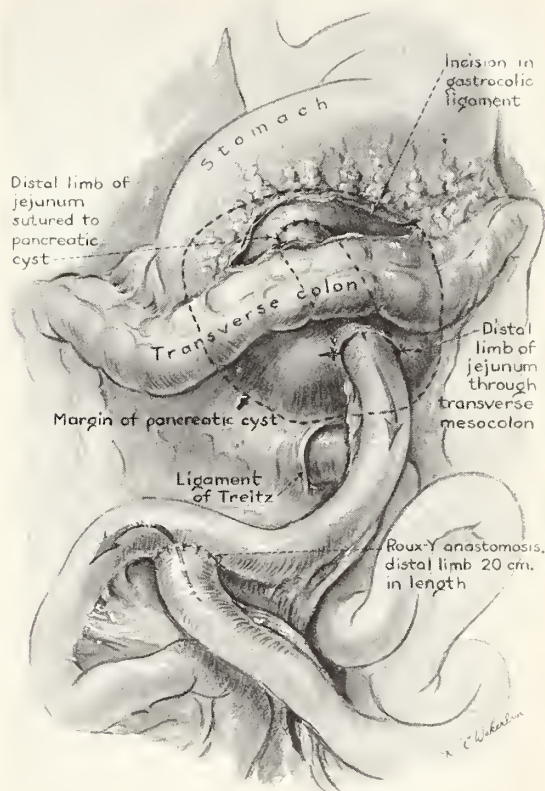


Figure 1. The management of pancreatic pseudocyst by internal drainage employing the Roux-Y principle. The defunctionalized limb of bowel should be at least 20 cms. in length.

pale mucous membranes, and the question of a tender mass in the left upper abdominal quadrant. The red cell count was 3,900,000, the white cell count 19,800, the blood amylase was 135 mgs. per cent, and the urine was free of sugar but contained a trace of albumin and a few pus cells. The fasting blood sugar on admission was 350 mgs., but repeated determinations after this showed the range to be within physiological limits. X-ray of the chest revealed a small amount of fluid at the left base, flat roentgenograms of the abdomen showed little of interest. An electrocardiogram revealed digitalis effects with ventricular premature beats. A diagnosis of an inflammatory intra-abdominal lesion, possibly due to a pancreatic abscess, was made, and the patient explored May 9, 1952, the sixth week of his illness.

Abdominal exploration was done through a left upper transverse incision, and this revealed marked fat necrosis and thickening of the gastrocolic ligament, with apparent fluctuation underneath it. After carefully identifying the

greater curvature of the stomach and the transverse colon, the gastrocolic ligament was incised releasing about two gallons of brownish, foul smelling pus. The thick walls of the abscess cavity were sutured to the parietal peritoneum, multiple, soft rubber drains inserted, and the incision closed with full thickness sutures of silver wire. He did well postoperatively for a time, but developed a severe urinary tract infection and died on June 4, 1952. The necropsy diagnosis was acute pancreatitis with abscess formation, acute ascending pyelonephritis, and multiple, small terminal pulmonary thrombi.

Case No. 3. (W.M.B.H., B-1336)—Mrs. H. R., white female, age 42, suddenly developed aching epigastric pain at 1 p.m., on January 1, 1947, with some radiation to the left and penetration between the shoulder blades. She had not had previous attacks. She vomited coffee ground appearing fluid, ran a low grade fever, and required opiates for the relief of pain.

She was admitted to the hospital on January 6, the most striking physical finding was that of a slightly tender epigastric mass. The white cell count was 9,500, the blood amylase 35 mg. per cent, and the urine clear aside from a small amount of albumin. X-rays of the gastrointestinal tract revealed extrinsic pressure defects on the hollow viscera consistent with a diagnosis of pancreatic cyst. At operation on January 13, 1947, a sanguino-purulent collection of fluid was evacuated from the body of the pancreas by means of an incision through the gastrocolic ligament. Her subsequent course was uneventful.

Case No. 4. (W.M.B.H., B-5683)—Mrs. R. H., a 47 year old white female developed severe upper abdominal pain 17 days prior to admission on February 3, 1948. During the preceding five years she had several somewhat similar attacks of pain, some of them with right subcostal radiation. She had a low grade fever but was not icteric.

The abdominal examination revealed a rounded, smooth, tender mass in the left upper abdominal quadrant. The urine was clear, the blood amylase was 42 mg., per cent, and the red and white cell counts within physiological limits. Fluoroscopic and roentgenographic examination of the gastrointestinal tract revealed the stomach to be displaced upward with an extrinsic pressure defect on the greater curvature.

She was explored through a short upper right rectus incision on February 6, 1948. Extensive fat necrosis with friable, vascular adhesions about the gallbladder, and a tense cystic like mass in the region of the tail of the pancreas were found. The rectus incision was closed, and the mass explored through a left transverse one. The gastrocolic ligament was opened, exposing a cystic mass in the pancreas. This was incised; a large amount of purulent material gushing forth. The abscess cavity was estimated to hold 500 cc. External drainage was accomplished by means of penrose drains. Bacteriological studies of the pus showed a hemolytic *Staphylococcus albus*. The patient's postoperative course was satisfactory and she was discharged on February 17, 1948, her twelfth postoperative day.

She was readmitted approximately five weeks later (April 25, 1948), complaining of having coughed up a large amount of purulent material some three weeks previously. She appeared to be anemic and chronically ill. X-ray of the chest showed what was thought to be an unresolved pneumonia at the left base. She was given blood transfusions, and the left upper transverse incision was reopened April 29, 1948, but no new abscess was found. It was thought that she undoubtedly had an abscess in this area with perforation through the diaphragm into the left bronchial tree. The left posterior superior subphrenic space was explored May 5, through a posterior approach, removing the left twelfth rib, but no abscess cavity was found. She was discharged greatly improved on May 10, 1948, and remained well until shortly prior to her third admission on May 12, 1950.

She complained of cramping upper abdominal pain with vomiting but no fever or jaundice. She was found to have gained a great deal of weight, with an obese, generally tender abdomen. The fasting blood sugar was 92 mg. percent, and the blood amylase 45 mg. percent. The clinical diagnosis was that of subsiding acute pancreatitis, or possibly acute cholecystitis. She left the hospital after three days and was told to have cholecystograms after losing some weight. She failed to do so, but has been heard from indirectly and is said to be doing well.

Comment

These four case reports serve to illustrate the most common sequelae of acute pancreatitis and their surgical management. Although

chronic, relapsing pancreatitis is occasionally listed as being a sequel to the acute form, one wonders whether or not it isn't a separate disease; certainly the management differs from the problems under discussion. The one patient with a pseudocyst did well with internal drainage and, although she has small gallstones, has remained asymptomatic. Cholecystectomy has been advised. The other three patients had an abscess form following an apparent attack of hemorrhagic pancreatitis, and, this, in spite of antibiotics, but in unknown dosage. Case No. 2 might have survived had the abscess been recognized and drained earlier. Case No. 4 might have escaped subsequent abscess formation, with rupture into a bronchus, had wider drainage been established by suturing the edges of the wall of the abscess to the parietal peritoneum at the first operation.

Summary

Pancreatic pseudocyst and abscess as sequels of acute pancreatitis have been discussed and some of the more important points in diagnosis and management presented. Four case reports have been briefly given; one of pseudocyst treated by internal drainage, employing the Roux-Y principle, and three of abscess treated by external drainage.

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WORLD LITERATURE ON CANCER ABSTRACTED

Excerpta Medica, the international medical abstracting service of Amsterdam The Netherlands, is initiating a new abstract journal, to be devoted to experimental and clinical work on cancer. The new publication will be Section XVI of this specialized abstract system, and will be similar in makeup and publication details to the 15 sections which have been published for several years. It will appear monthly and will abstract the world literature. One issue each year will also contain a subject and author index for the year. The work is aided by grants from the National Cancer Institute of the U. S. Public Health Service and the American Cancer Society.

LIVER DISEASE: A Surgeon's View*

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ROBERT P. LLOYD, M.D.‡

Philadelphia

IT IS UNNECESSARY to say that I am extremely honored to be a member of this panel of illustrious medical men and surgeons and consider it a distinct privilege to be here.

Dr. Anton J. Carlson of the University of Chicago one time classified liver disease into three simple categories. He said that he liked to think of liver disease in terms of those things that happened before the liver; those things that happened in the liver; and those things that happened after the liver. This is a most simple classification but one that fits itself admirably to the division of the liver between the medical men and the surgeons. The surgeon finds himself most interested in those things that occur before and after the liver and certainly if he is honest must recognize his limitations in the treatment of those things that occur in the liver proper. It is true that the surgeon can occasionally excise a hemangioma, although this may well be a hazardous procedure; he may drain an abscess; he may marsupialize an Echinococcus cyst or he may resect a solitary metastasis, but other than these things which do not happen often in the life of any surgeon, the treatment of other intrahepatic disease is largely a medical problem.

When we speak of diseases before the liver we speak primarily of hemolytic icterus. In this disease process there is an excessive formation of bilirubin due to the rapid break down of red blood cells. The inability of the hepatic cells to excrete the bilirubin as rapidly as it is formed, in most cases, results in icterus, and

when the red cells can be proven to be more fragile than normal, splenectomy is many times almost specific, particularly in the congenital form of the disease. One may expect good results in as many as 85 percent of the people who are splenectomized for congenital hemolytic icterus and perhaps 45 percent to 50 percent of those with the acquired type of disease are benefited as well. You are all familiar with the Coombs test which is used to differentiate the congenital from the acquired type and we feel that the Coombs test is important chiefly from the standpoint of acquainting the patient and the family with what they may expect of the procedure inasmuch as there is an appreciable difference in results in the two groups. So much for diseases before the liver.

The diseases after the liver are many but practically all of them involve one single principle which makes them amenable to surgical treatment. Practically all these lesions present themselves to the surgeon on the basis of biliary obstruction and its subsequent jaundice, cholangitis, and after a time, liver destruction. We in our group feel that there is definitely room here for clinical acumen and observation as well as a highly scientific laboratory approach. By that we mean that the average liver function test is sufficiently coarse that by the time it becomes markedly positive the patient is already a rather poor operative risk. We have come to respect tremendously the therapeutic test with vitamin K. One of the results of biliary obstruction is the lack of absorption of fat in the absence of bile salts in the intestinal tract. Vitamin K, being a fat soluble vitamin, is not absorbed from the intestinal tract in this instance and in the absence of vitamin K the hepatic cells are unable to elaborate prothrombin so that when the prothrombin time is tested it is found

* Presented as part of a panel discussion on "Management of Liver Diseases" at the annual convention of Indiana State Medical Association October 30, 1952.

† Doctor Bolman is chief surgeon at St. Joseph's Hospital, Fort Wayne. He presented the paper.

‡ Doctor Lloyd is chief surgical resident at Hahnemann Hospital, Philadelphia.

to be grossly deficient, perhaps as low as 30 percent to 50 percent of the normal. Now in a situation where the liver has not long been obstructed and is not badly damaged a therapeutic dose of 10 mg. of vitamin K daily for perhaps three days will rapidly return the prothrombin time to normal, whereas the same amount of vitamin K in a badly damaged liver will leave you with a still deficient prothrombin time and we consider this to be a grave prognostic sign in so far as the patient's ability to withstand extensive surgery is concerned.

It is a well known fact technically that the distended, large extra-hepatic bile ducts of obstruction are the best candidates for surgical intervention in so far as identification and manipulation are concerned. Despite this technical truth in a patient whose liver is so grossly damaged as to be unable to elaborate prothrombin, we have had several patients in whom we felt the only safe procedure was one which supplied them with an external biliary fistula and allowed their liver function to improve for as long as 6 weeks to 3 months with adequate biliary drainage before an extensive surgical procedure was undertaken. During this time we have re-fed the bile up to as much as 500 ccs. daily and, much to our surprise have found that the patients who were re-fed the bile rapidly found that they felt tremendously better when they had the bile and were perfectly willing to drink it icecold thereby obviating the necessity of feeding it to them with a tube. By this course of treatment, that is to say the drainage and re-feeding of bile together with the supplying of adequate amounts of vitamin K, proteins, vitamins, minerals and electrolytes, a patient can be changed over a period of 6 to 8 weeks from one who is an extremely tottery surgical risk to one upon whom a long drawn out biliary reconstructive procedure can be undertaken with a reasonable amount of safety.

As a complication of long continued biliary obstruction in addition to the destruction of the hepatic parenchyma which one expects, if the element of infection is superimposed, multiple abscesses of the liver are many times present. These may be very small and very numerous. It has been our experience with these that adequate biliary drainage be it internal or external, will in most cases drain the abscesses and restore the liver to a condition somewhat resembling normal without draining each individual abscess. Any

surgeon of extensive experience has seen patients following accidental destruction of the extra-hepatic biliary ducts wherein the liver is dark green and hard and its surface studded with many miliary abscesses which, after adequate external biliary drainage, disappear and the liver takes on a completely different aspect even grossly.

Here, perhaps, a word should be said about the preparation of these patients for surgery. We pay most attention, as I said before, to the response of the liver to adequate doses of vitamin K. In addition we are most interested in the level of the blood proteins and the albumin globulin ratio. In most cases of extra-hepatic biliary obstruction which have followed previous surgery one is faced with an emotional situation as well as a surgical situation. The doctor who refers the patient for treatment is most anxious to have something done and the family, already having undergone one surgical procedure, is also most anxious to have something done and that in a hurry. It is in these cases that the surgeon must adopt a firm approach to the problem and spend some considerable time convincing the family and sometimes even the doctor that a certain amount of time spent in preparation will give this patient a much better opportunity for recovery and that the time spent prior to surgery will be more than made up for after surgery in the patient's hastened recovery. We make a practice of never operating a long standing obstructive jaundice without a minimum of 5 to 7 days preparation. Our preparation consists of those things which the patient will tolerate by mouth and of these we do our level best to supply an overadequate amount of protein. There is no point in feeding the patient any fat of any kind because it will not be tolerated. The patient is given intravenous hypertonic glucose fortified with vitamins daily and at least two blood transfusions are given prior to surgery regardless of the patient's blood count. We belong to the group that feels that if a patient needs protein, he needs blood. This has seemed to us to come closer to correcting the prothrombin deficiency than other measures, and certainly does more toward the correction of the protein deficiency than any of the amino acids or protein hydrolysates. There has been much talk recently about decreasing the amount of blood used during surgery and we are in sympathy with much of this. However, in this

particular situation, where one is faced with a patient that is deficient in protein and who, following surgery, in most cases has a surgical field that will continue to ooze for some hours following surgery, blood before surgery, during surgery and after surgery we consider to be a life saving procedure. Many of these procedures require 4 to 6 hours of operating time and for that reason the patient needs to be fortified before the surgical procedure is undertaken.

We do not share the belief of many that the reconstructive operations for destroyed extra-hepatic biliary ducts uniformly lead to an ultimate poor result, but feel rather that there is no field in surgery where one's results can be so gratifying, if one will only take the time to be meticulously careful in the establishment of a physiological situation for the drainage of bile into the intestinal tract. We feel that the connection of the gallbladder or the common duct or either of the hepatic ducts to a functioning loop of intestine is a procedure that should be reserved only for urgency or for a patient in whom you are doing a palliative procedure in the presence of malignancy. The cholangitis which follows the connection of the gallbladder or one of the biliary ducts to a functioning loop of intestine or to the stomach is a very real complication and will occur in almost 100 percent of cases. If any duct can be found whatsoever, even at the hilus of the liver our preference is for the Roux-en-Y procedure using a loop of jejunum perhaps 18 inches distal to the ligament of Treitz and defunctionalizing a loop 16 to 18 inches long to completely prevent the reflux of gastro-intestinal contents into the biliary system. We have a sizable number of these patients in circulation and find that they do well, eat well and escape the attacks of chills, fever and recurrent jaundice that are so common when functioning bowel is used. Just last Monday we reoperated a man who had been in poor physical condition when we operated him 2 years ago and because we were fearful of his ability to stand a major procedure a cholecystenterostomy was done. This man has had recurrent attacks of chills, fever and jaundice recently and last Monday we reopened him to establish physiological connection between the liver and the bowel so that this man can live out the rest of his life without further difficulty. If no ducts can be found whatsoever, even at the hilus of the liver, our preference is for the

operation of Longmire of California whom, we feel, made an excellent contribution with his so-called intra-hepatic cholangiojejunostomy. It was this operation that took advantage of the fact that there is a cross over of drainage from the right and left hepatic lobes so that it is possible to drain both lobes of the liver through the left hepatic ducts. We feel that the technical secret in these procedures is the careful, accurate apposition of mucosa to mucosa with fine nonabsorbable suture material and that these anastomoses should be uniformly supported by a catheter for 14 to 18 days postoperatively. It is certainly advisable, in the construction of an anastomosis between a biliary duct and the intestine, to make the diameter of the anastomosis as wide as one possibly can by incising one side of the biliary duct and turning it out so as to have maximum breadth which will allow for an adequate opening once healing and scar tissue formation have taken place.

Because it has been reasonably well proven to be essential to support these anastomoses with catheters for 14 to 18 days, we are not in favor of the procedure recommended by Lahey and Dragstedt, namely that of mobilizing the distal portion of the common duct, the so called retro-duodenal or intra-pancreatic portion of the common bile duct and doing a primary end to end anastomosis with the stump of a common duct above or perhaps with an hepatic duct, unless there is room to install a 'T' tube above or below the point of anastomosis. That is to say, we are not in favor of this type of anastomosis when it is necessary to pass a catheter across the anastomosis and bring it out through the anterior wall of the duodenum surrounded by a purse string suture. In this particular instance the catheter is brought out through a duodenum which is functioning completely and a duodenal fistula is certainly a complication to be avoided rather than to be sought. For this reason we are not in favor of any procedure which requires bringing a catheter out through the anterior wall of an active duodenum. We would rather use the Roux-en-Y principle with a loop of jejunum unless there is adequate room to apply a 'T' tube across the anastomosis which obviates the necessity of establishing a fistula from the anterior duodenal wall. The suture material used in these anastomoses must be of the finest possible variety, our preference being 'C' silk or so called No. 4-0 silk, interrupted sutures.

It has been suggested that rather than go to the difficulty of constructing a Roux-en-Y loop it is perfectly satisfactory to use an 'in-tact' loop of jejunum, with an entero-enterostomy at the base of the loop as a sort of short circuit for the gastrointestinal contents. This is certainly an unphysiological procedure inasmuch as the peristaltic gradient favors the passage of gastrointestinal contents up around the loop and down, rather than through the entero-enterostomy, and for that reason we do not use this procedure.

We have completely abandoned the use of the vitellium because of its tendency to migrate and its tendency to become plugged, and at the moment we know of no situation where a vitellium tube is necessary that a primary mucosa to mucosa anastomosis cannot be done instead. The only other alternative method of establishing biliary continuity is the old uncommon common duct of McArthur wherein an external biliary fistula was intentionally established and then the fistula dissected free and implanted into the intestinal tract to be used as a common duct. It has been well shown many times that it is impossible to dissect free and mobilize the fistulous tract without interfering with its blood supply sufficiently to encourage the formation of stricture after it is implanted in the intestinal tract. This procedure is mentioned only for the purpose of historical completeness and finds no place in the modern surgeon's armamentarium. So much for obstructive biliary processes after the liver.

There is another class of situations in which the surgeon must be concerned constantly with liver function. I refer to that group of cases particularly among the older patients wherein the surgeon is faced with a necessary operative procedure completely unrelated to the liver but wherein the success of the surgical outcome depends on whether or not the patient's liver function is adequate. One might cite as an example a patient with a carcinoma of the colon who has a liver function that has been barely adequate to maintain him without surgical intervention and with surgical intervention and the necessary detoxification of the anesthetic agents the patient undergoes what we choose to call hepatic decompensation. The situation is much the same as one sees in a patient whose heart is barely adequate for every-

day living, but wherein a surgical procedure superimposed on the normal stress of everyday living is sufficient to produce cardiac decompensation. This is a fine point in clinical judgment and it behooves the surgeon at all times to remember that just as the heart and lungs accompany him constantly in his estimation of surgical risk so also the liver is the constant companion of his morbidity and mortality. One does well to bear this in mind and in the physical examination of the patient remember to be mindful of the distended abdominal veins, the spider sign of Patek, the slightly swollen ankles, the sallow complexion, the palpable liver, the slight anemia, the leukopenia, the suggestion of abdominal fluid, the slightly elevated nitrogenous waste products in the blood, the cephalin flocculation and the prothrombin deficiency all of which are the earmarks of the liver which is barely capable of carrying on with the mere stresses of everyday living. When this liver is asked to react to the superimposition of a serious surgical procedure a fatal outcome may well ensue for a patient whose chances of recovery would otherwise seem to be excellent. The estimation of these things preoperatively; their adequate evaluation and placement and taking them into consideration when rendering a prognosis to a family before an operative procedure, make up many of the things which enable us to create good surgical public relations. I am sure all of us find that those things about which we are able to warn our patients and their families in advance are those things for which we are not blamed. On the other hand if one overlooks the increased risk that goes with an inadequate liver he may suddenly have to explain an unexpected surgical outcome for which the patient's family was completely unprepared.

The surgeon has a third class of liver disease in which he must be interested, namely the surgical treatment of portal or so called Laennec's cirrhosis with portal hypertension. Evidence is being accumulated rather rapidly now which within a reasonably short time should enable us to estimate the true value of the so called porto-caval shunts, be they lieno-renal or be they true porto-caval. One must bear in mind that these are not operations aimed at the curing of cirrhosis of the liver but rather operations merely to lower the tension within the por-

tal circulation and thus let the patient avoid the almost certain death that accompanies a bleeding esophageal varix or perhaps to relieve an intractable ascites. In so far as any one has been able to prove the porto-caval shunt operation does not improve liver function nor does it cure cirrhosis of the liver, but it does enable the patient to live in reasonable comfort until the cirrhosis progresses to that point at which it overtakes vital functions without which life cannot be supported. One of the early fatal complications of cirrhosis of the liver is the bleeding esophageal varix and many times with the lowering of tension which accompanies a porto-caval shunt a patient can live a reasonably long time before one of the other vital functions of the liver is interfered with. These operations are still associated with a very respectable mortality and for that reason have been reserved for those patients whose outlook is otherwise minimal.

To summarize then, the modern surgeon is interested in three aspects of liver disease. First, the surgeon is interested in those diseases of the liver which by direct or indirect attack are amenable to surgical therapy, chiefly decompression and adequate biliary drainage to allow for the rehabilitation of the hepatic cells. Second,

the surgeon is interested in that class of liver disease which is unrelated to the pathology at hand but in which the adequate liver function is so necessary to the successful outcome of an unrelated operation and third, the surgeon is interested in those situations associated with portal cirrhosis of the liver in which decompression and reduction of the tension within the portal system is necessary to prevent exsanguination from esophageal varices.

We are indeed indebted to the physiologists and internists for our increased knowledge of liver function, both normal and diseased, and certainly we are indebted to the anesthesiologists for the advancement of their specialty to the point that it is possible to administer a general anesthetic over a long period of time to a patient with a minimal amount of increased liver stress, in those patients in whom the amount of stress is so all important.

May I again express my sincere appreciation for being asked to participate in this panel and I sincerely believe it is only by the exchange of ideas and opinions of people whose medical situations are widely divergent that we may all deliver the very best medicine and surgery available to that all important part of the medical profession, the patient.

AUTOIMMUNIZATION IN HEMOLOGICAL DISEASES*

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IN 1939 Levine and Stetson¹ described a new human blood factor which was independent of other known substances, A, B, M, N, and P. This atypical agglutinin was thought to be responsible for a severe reaction in a recently delivered woman at her very first transfusion. The serum of the patient agglutinated the cells of 80 percent of Group O individuals. Landsteiner and Wiener^{2, 3} (in 1940) demonstrated that agglutinins developed in laboratory animals against the red blood cells of *Macaca rhesus* monkeys would also agglutinate the corpuscles of 85 percent of human individuals regardless of isoagglutinin groups. The agglutininogen in human corpuscles responsible for the reaction was termed the "Rh factor." It became apparent that the human Rh factor was probably identical with that previously described by Levine and Stetson.¹ The detection of abnormal antibodies in various disease states has been greatly facilitated since that time by the development of several new technics by the workers in the Rh field.

The old methods, using salt solution as a diluent, have been shown to possess low grades of sensitivity, which may result in the complete failure to find antibodies present in high concentration. The new methods for antibody detection include the use of bovine albumin as a diluent,^{4, 5} the Coombs' test⁶ in which anti-human globulin rabbit serum is used, and the use of trypsinated red blood cells.⁷ Cross-transfusion experiments had previously suggested the presence of circulating hemolysins in patients having acquired hemolytic anemias.

Employing these methods it was shown^{5, 8, 9} that in almost all patients who have acquired

hemolytic jaundice abnormal immune bodies can be demonstrated. These abnormal hemolytic antibodies are present in both the "idiopathic" and symptomatic (secondary) types of the disease. These result in red cell injury and diminished red cell survival time, and subsequently lead to the development of hemolytic anemia. These abnormal antibodies are classified as "warm" iso- and auto-agglutinins, "cold" iso- and auto-agglutinins, and "warm" iso- and auto-hemolysins. Dameshek,⁹ and Evans and Duane¹⁰ have shown that there is rough correlation between the concentration of antibody and the red cell survival time (transfused normal cells) and the activity of the hemolytic process. "Symptomatic" acquired hemolytic anemia with abnormal antibody formation occurs in certain types of infection, mainly viral infections, and in disease processes commonly associated with lymph node involvement such as leukemia, lymphosarcoma, Hodgkin's disease, infectious mononucleosis, Boeck's sarcoid, and metastatic carcinoma. This suggests that a virus, a form of white cell proliferation or other disturbance in the lymph glands may cause cellular changes, with the result that certain abnormal globulins are produced having the function of an antibody. Serological red cell abnormalities in idiopathic cases are indistinguishable from those in so-called symptomatic cases. Auto-immune hemolytic disease should always be considered as a possibility in any patient having refractory anemia, mild icterus, splenomegaly, persistent reticulocytosis, hemoglobinemia or hemoglobinuria.

Discover Offending Drugs

Evans and his associates^{10, 11} have pointed out the common occurrence of thrombocytopenia and leukopenia in acquired hemolytic anemia as well as the occurrence of mild hemolytic anemia in primary thrombocytopenia. They indicated the features common to both acquired hemolytic anemia and thrombocytopenic purpura which

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suggest a close relationship between these disease syndromes. Platelet agglutinating substances in the blood of patients with thrombocytopenic purpura have been demonstrated.^{11, 12} Bigelow and Desforges,¹² however, found that quinidine had to be added to the plasma before the agglutination of the platelets occurred. The thrombocytopenia in their two patients resulted from quinidine sensitivity. They suggested that the addition of suspected drugs to the plasma of patients and the determination of the platelet agglutinating power of the plasma offered a method of discovering the offending disease-producing drug (in their patients, quinidine).

Further proof of the presence of the thrombocytopenic factor in the blood of patients suffering from thrombocytopenic purpura was demonstrated by the transfusion of their blood into normal human volunteers.¹³ The administration of 500 cc. of citrated whole blood or its plasma equivalent from eight patients with idiopathic thrombocytopenic purpura and from one with secondary thrombocytopenia caused a prompt, and often dramatic, decrease in the platelet counts of normal individuals. The entire clinical and laboratory syndrome of thrombocytopenic purpura was induced in two recipients within the first few hours. The effect persisted for from five to seven days. Two subjects still had the thrombocytopenic factor after their platelet counts had returned to normal following the removal of the spleen. The factor could not be demonstrated in one patient after a clinical and laboratory response following the administration of Cortisone. In addition it has been shown^{14, 15} that platelets transfused into persons with idiopathic thrombocytopenic purpura disappeared promptly (in one-half to 12 hours), while platelets transfused into a person with secondary (amegakaryocytic) thrombocytopenia persisted longer (48 hours to 6 days).

As pointed out previously,¹⁰ leukopenia often accompanies acquired hemolytic anemia due to circulating antibodies. Likewise, Moeschlin and Wagner¹⁶ demonstrated that the transfusion of 300 cc. of blood from a patient sensitive to Pyrimidon who had received 0.3 gm. or 0.6 gm. of the drug, produced a prompt decrease in the white blood cell count of normal recipients. They believe that the agranulocytosis results from agglutination of granulocytes with subsequent destruction.

It would therefore seem that in many instances acquired hemolytic anemia, thrombocytopenic purpura, and agranulocytosis result from autoimmunization initiated by certain chemicals, infections, allergic reactions, white cell proliferations or other diseases involving the lymph nodes and spleen. In consideration of this fact several methods of therapy suggest themselves. The removal of antibody-producing organs or tissue is rarely possible, as in the removal of a dermoid cyst of the ovary in a patient who has hemolytic anemia.⁹ Splenectomy removes a large mass of antibody-forming tissue and, in addition, removes an organ which has been shown to be active in the destruction of red blood cells, platelets, and granular cells. It has been an almost universal finding that splenectomy is highly successful in over 50 percent of these patients although results are uncertain—that is, it is impossible to predict which patient will or will not respond to this treatment. The circulating antibodies may decrease or entirely disappear following splenectomy.^{9, 10, 11} The persistence of high antibody titers after splenectomy, however, indicates that all the antibody-forming tissue has not been removed and suggests that a relapse may occur at any time, (as has often been the case in patients showing an initial response to splenectomy).

Results Not Uniform

Neutralization of the antibodies by transfusion has not been given extensive trial, but the occurrence of "spontaneous remissions" in patients having thrombocytopenic purpura following transfusion with polycythemic blood^{14, 15} suggests that this might have been accomplished. Numerous attempts have been made to decrease antibody formation. The administration of nitrogen mustard,⁹ radioactive gold,⁹ and triethylene melamine¹⁷ has been followed by a decrease in antibody titers in some patients with hemolytic anemia—both the idiopathic and symptomatic types—with a resultant marked decrease in the hemolytic process. Uniformly successful results have not been observed however. The finding that the administration of ACTH and Cortisone caused diminution in the amount of lymphocytic tissue and that antibody production was altered suggested their use in acquired hemolytic jaundice and thrombocytopenic purpura. These hormones have been

found to greatly modify the disease states in some of these patients, but not in all.^{9, 17-21} Their administration in preparation for splenectomy has been suggested by Dameshek, Rosenthal, and Schwartz.¹⁹ Complete and sustained remissions were reported²¹ in 5 of 17 patients with thrombocytopenic purpura. Dameshek states⁹ that "the effect of ACTH in acquired hemolytic anemia is striking indeed, and there seems little doubt that a very definite effect on antibody production takes place."

Summary

It would appear that acquired hemolytic jaundice, thrombocytopenic purpura with megakaryocytes in bone marrow, and some cases of agranulocytosis are initiated by various agents including certain chemicals or infections, white cell proliferations and other disease processes of lymphatic glands and spleen. The resulting autoimmunization causes injury to the patient's own red cells, platelets or granular cells. These antibodies differ in their physical and chemical properties, and probably represent different types or degrees of alteration of serum globulin that can be demonstrated by various new techniques. Therapy should be directed toward removal or neutralization of these antibodies.

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TRACHEOTOMY: PRESENT DAY INDICATIONS AND TECHNIQUES

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IN THIS DAY of progressive surgery, there are many new applications for old surgical procedures. Tracheotomy, which has been employed more commonly during the past few years, is one such procedure. Many physicians think of tracheotomy only as an operation which is carried out when a patient has an obstructed airway and is cyanotic. One of the purposes of this paper is to point out the fact that, in most instances, a tracheotomy may be a carefully planned and an orderly prophylactic procedure.

Many patients who were candidates for tracheotomies were observed at the Indiana University Medical Center and 16 tracheotomies were performed by the author. This paper presents the observations of the author while a resident physician at the Ear, Nose & Throat Section of the Indiana University Medical Center.

Tracheotomy is the establishment of an artificial airway through the soft tissues of the anterior neck to the trachea. Indications for such a procedure include:

Micrognathia.—This is a condition in which a patient cannot support his tongue anteriorly. As a result, the tongue falls backward against the posterior pharyngeal wall and occludes the airway. This situation may be temporarily alleviated and suffocation avoided by placing a suture through the tongue and anchoring it to hold the tongue forward. A patient treated in this manner must have a special nurse or attendant at all times but it is the opinion of the author that it is much safer to tracheotomize such a patient. It is true that such a tracheotomized patient also requires an attendant 24 hours a day, but the chances of suffocation are lessened with this airway. The tracheotomy tube may be left in place until the patient is old enough or in condition to maintain his airway without difficulty.

Diphtheria.—The diphtheritic pathology may

be located primarily in one portion of the nose, pharynx, trachea or bronchi, or it may involve several or all of these areas. If it involves the nose primarily, there will be little respiratory difficulty. However, if it involves the larynx, trachea, or bronchi, respiratory difficulty will be experienced. The degree of this will depend upon the severity of the infection and the age of the patient.

If a patient is seen relatively early in the disease and has an adequate airway, is not cyanotic, and his general condition is fair, he may be placed immediately in a small room (preferably one with a glass wall partition so that the doctor and other members of the staff may observe the patient at frequent intervals without entering the room). The room should be cool, and the air moist, since a very moist atmosphere usually improves the patient's condition. This can best be accomplished by the use of a fan-type water vaporizer. Because of the temperature and humidity, it is important to keep the patient warm; cotton pajamas and blankets may be used. Blankets should be checked frequently to see that they do not become soaked. The patient may be given oxygen by nasal catheter or through a funnel supported over the nose and mouth and connected to a source of oxygen. The room should be relatively quiet and only those actually caring for the patient should be allowed to enter and leave. A tracheotomy set should be available in the room.

It is especially important to check for restlessness in patients under observation. The more limited the airway, the more restless the patient will be unless he is terminally ill. A tracheotomy should never be performed on a patient whose airway is adequate enough to allow sleep.

The pulse and respiratory rates should be recorded at frequent intervals as an aid in determining the necessity for a tracheotomy. The type of respirations should be observed by the staff. If the patient has marked suprasternal and infrasternal retraction becoming progres-

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sively worse, a tracheotomy is indicated. The color of the patient should be observed and the tracheotomy performed before the patient becomes cyanotic.

Postoperative care is very important. Tracheotomized diphtheritic patients are prone to develop thickened, dry secretions in their trachea and bronchi; often casts of the trachea and bronchi may be formed. It is imperative that these secretions and casts be removed if possible. It may be necessary to remove the tracheotomy tube and pass a bronchoscope through the tracheotomy to remove this material. There is no assurance that the airway will be patent once the tracheotomy tube is in place and the tracheotomized patient must be watched as closely postoperatively as he was preoperatively.

Laryngotracheobronchitis.—Children who have this disease may become candidates for tracheotomy within a few hours. They should be placed in the same type of vaporized room used for early diphtheria patients. Often, 24 hours of such conservative treatment will make tracheotomy unnecessary. In patients who require tracheotomy, however, the cannula may be removed in two or three days.

Tetanus.—In some cases of tetanus, constant sedation is necessary. Sedated patients, of course, may aspirate accumulated pharyngeal secretions and because of their suppressed coughing mechanism, they may develop obstructions in their tracheobronchial tree from these secretions. Early tracheotomy will usually decrease the duration of the disease and will definitely improve the patient's chances of recovery.

Polomyelitis.—In the treatment of this disease it is important to maintain a good airway. This usually involves the removal of secretions, but in some instances may involve the establishment of an artificial airway. Tracheotomy may be necessary in the following type of patients: Those who have considerable secretions in their airways; respirator cases, especially those who are semiconscious or unconscious; patients who develop atelectasis; and those who have bilateral laryngeal paralysis.

The manner of performing a tracheotomy on a patient who is a respirator case is as follows: The anesthetist inserts an endotracheal tube; the respirator is shut off, the anesthetist then gives artificial respiration using positive pressure with

oxygen and a breathing bag. The patient is removed from the respirator and taken to the isolation surgery room; the tracheotomy is performed and the tracheotomy tube inserted as the endotracheal tube is removed. Immediately, an endotracheal tube is inserted into the outer tracheotomy tube and artificial respiration is continued through this airway. The patient is placed in a special type respirator which has an angle head; a special neckpiece for tracheotomized patients is employed; the respirator is started and the endotracheal tube removed. Oxygen may then be given through the tracheotomy tube. The foot of the respirator is elevated to promote drainage from the bronchi into the trachea. Only one attendant is needed for the care of several tracheotomized patients.

It should also be emphasized that if a tracheotomy is to be performed, it should be done early in the disease as the patient is more apt to benefit from the procedure at that time.

Foreign Bodies.—Any child who aspirates a foreign body is a candidate for tracheotomy and the younger the child, the greater is this likelihood. In cases where it is necessary to pass the bronchoscope through the larynx only once and the foreign body is easily removed, a tracheotomy usually will not be necessary. In patients who require several introductions of the bronchoscope to remove the foreign body, a tracheotomy may be necessary because of the resulting laryngeal edema. It is impossible, in some instances, to remove the foreign body through the larynx because of the size of the object, and a tracheotomy must be performed (the operation may be performed with a bronchoscope in place). A bronchoscope may be introduced through the tracheotomy so that the foreign body may be more easily removed. It is important for the operator to introduce the bronchoscope into the trachea above the tracheotomy opening as well as below, since a foreign body may be lodged between the level of the vocal cords and the tracheotomy.

Facial Injuries.—Automobile and military accidents cause severe facial injuries in many patients. If an obstruction of the airway occurs, these patients require immediate tracheotomy. Some may require a tracheotomy prior to surgical correction to assure an adequate airway postoperatively. Many of these patients may be relieved of this artificial airway after recovery.

Neurosurgery.—Primarily, there are two uses for tracheotomy in neurosurgical patients: Brain injuries resulting in semiconsciousness or unconsciousness, and extensive neurosurgical procedures where expected semiconsciousness or perhaps unconsciousness follows the surgery. If it is necessary to place neurosurgical patients in respirators, the treatment should be similar to that given poliomyelitis respirator patients.

Papilloma.—Children who have papilloma of the larynx often require numerous laryngoscopies and removal of the papillomatous tissue. When a diagnosis of laryngeal papilloma is made in a young child, a tracheotomy is usually done to assure the patient an adequate airway, especially after laryngoscopy and biopsy. The tracheotomy also facilitates the giving of the anesthetic. Some children are cured of papilloma in which case the tracheotomy tube may be removed and the wound closed.

Carcinoma.—Patients may have malignancies of the tongue, hypopharynx, and larynx which produce obstruction of the airway. If these malignancies are allowed to progress too far before medical advice is sought, the obstruction may be so great that immediate tracheotomy may be necessary. In many of these patients, radiation therapy is given. Because of the tissue swelling which sometimes results from radiation therapy, it is well in some cases to do a prophylactic tracheotomy. Several weeks after radiation is completed, if it is determined that the airway will be adequate, the tracheotomy wound may be closed.

Technique.—If a patient is a child, he must be restrained in order to facilitate the procedure. This can usually be accomplished by "mummifying" the patient, but the anterior chest should not be covered when this is done. One of the most important practical anatomical rules is that, if possible, the trachea should be in the midline; this position is certain if the patient's nose, chin, laryngeal prominence, and sternal notch are in a straight line.

The skin incision may be made with a knife. The remainder of the dissection, with the exception of the tracheal incision, may be accomplished with the use of a hemostat. If possible, all bleeding points should be controlled before the trachea is entered. The tracheal fascia should be infiltrated with novocaine immediately

before it is incised. The surgeon should not peel the tracheal fascia off the trachea as this invites development of pneumomediastinum. In making the incision through the tracheal wall and cartilages, the surgeon should hold his right index finger against the side of the blade to prevent the accidental incising of the posterior wall of the trachea and the entering of the esophagus. After the incision is made, the tracheal dilator should be used to prepare an opening for the tracheotomy tube. Following the insertion of the tube, the patient's breathing may be stimulated by the administration of carbon dioxide.

The large veins usually encountered when performing a tracheotomy should be tied first and then cut. This order will prevent air from being sucked into the vein and thereby producing an air embolus. The tracheotomy wound is always left open (the incision is not closed tightly around the tube with sutures).

Complications of Tracheotomy

1. *Perforation of the Esophagus.*—The possibility of perforating the esophagus, at the time of surgery has already been mentioned. A perforation into the esophagus from the trachea may result from damage to the posterior tracheal wall by careless manipulation of the tracheotomy tube.

2. *Subcutaneous Emphysema.*—Fortunately, this is not a common complication. This condition is likely to develop if the patient must struggle for air at any time during or following the procedure. The resulting subcutaneous emphysema may be very extensive. Pneumomediastinum and pneumothorax may appear separately or with subcutaneous emphysema.

3. *Postoperative Bleeding.*—The bleeding may be slight and may come from a small skin vessel. However, the bleeding may result from the erosion by the tracheotomy tube of one of the large vessels at the base of the neck and may prove fatal.

Closure of the Tracheotomy.—After the need for the artificial airway is past, the tube may be removed. If the tracheotomy was recent (within three or four weeks), the opening will close if the edges of the wound are approximated and held in place with adhesive tape. If the tracheotomy was not recent and the tract has become

epithelized, it may be necessary to cut out the cylinder of epithelium. The surgeon should close the tracheal opening first with a purse string type of suture. Failure to do so may result in the development of subcutaneous emphysema. The subcutaneous tissue and the skin may then be approximated.

Summary

Many indications for tracheotomies have been presented and the decrease in morbidity and the life-saving value of this procedure shown.

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ROSTER CORRECTIONS REPORTED

In the Delaware-Blackford county section of the roster of members of I.S.M.A. in the Medical Yearbook, Dr. R. M. McMichael is listed at 324 West Adams Street, Muncie. Correct address is 324 West *Jackson* Street, Muncie.

Harry M. Shultz, M.D., senior member of the I.S.M.A., has been listed incorrectly in both alphabetical and Cass County rosters for the last three years as *Henry* M. Shultz. We're sorry!

Please continue to advise THE JOURNAL of any errors in names or addresses in the membership roster published in the July Yearbook.

THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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Office of Publication: 1017 Hume Mansur Building

Indianapolis 4, Indiana

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TREATMENT OF ALCOHOLICS

THE RECOGNITION of alcoholism as a disease is not a new concept. However, in spite of ample evidence to support this medical opinion, and in spite of the magnitude of the problem, compulsive drinkers have been mishandled by society for many, many years.

It is only within the past decade or so that the management of this great public health problem has been put on a rational basis. And, even during the past few years of greatest progress, the advances and general acceptance of proper control measures has been exceedingly slow.

The inertia of public opinion, and the ease with which a "down and out" alcoholic may be classified as a bum, and thereafter handled and cared for as such, has contributed to delay in adopting a program which will function more realistically.

In 1950 during its meeting in Cleveland, the American Medical Association adopted a resolution which accepted the problem on a national scale. Since then many state medical

associations, including Indiana, have likewise acted. During the past two years our Committee on Alcoholics Study has actively analyzed the situation in Indiana. As a result of their recommendations the General Assembly passed into law a plan for medical treatment of problem drinkers.

There are at least 3,500,000 compulsive drinkers in the United States. From all indications Indiana is responsible for its fair share of this problem. An unknown but rather high percentage of the alcoholics will require some sort of treatment.

Funds for the activities of the commission are provided from a tax on liquor. The funds are ample and need to be, since although pioneer work has been done in other states, there is much basic information to be obtained from our own state, before definite plans can be made.

As this important work progresses continued interest and advice of the medical profession at large will be necessary.

CARE OF PREMATURE INFANTS

IN THIS ISSUE is an article on the premature infant prepared by the Maternal and Child Health Division of the Indiana State Board of Health in cooperation with the Indiana State Medical Association Committee on Maternal and Child Health. This is not intended to be a directive to the profession,

but is offered as reference material for the doctor and as a guide to hospitals. The latter function should be of distinct benefit to those physicians who are endeavoring to improve the care of prematures in hospitals which may not have paid special attention to this problem.

JENKINS-KEOGH BILLS

DURING the autumn months, while Congress is in recess, congressmen will be spending some of the time in visiting their constituencies. One of the things about which doctors should talk to their congressmen are the Jenkins-Keogh bills. These bills are almost identical to the Reed-Keogh bills of the previous Congress.

The bills propose that self-employed individuals be allowed to build up pension funds by investing a portion of their current income free of Federal income tax. This would make it possible for physicians, lawyers, engineers and all other self-employed citizens to set aside a limited amount of their income in specified investments, and pay income taxes on this amount only when it is withdrawn from savings at a later date.

Thus, limited amounts of a relatively high income at the present time would be exempted from the higher brackets of tax, and would fall into lower brackets later when

incomes of old age and retirement are smaller.

This is not a special privilege measure, but simply a means of correcting an inequity in the income tax law. Employed persons may, at the present time, have their pension funds built up with tax exempt contributions. Self-employed persons do not have this right. The proposed law would amend the income tax law, so that the employed and self-employed would both enjoy this advantage.

The measure is of special interest to professional people whose period of training is long and is associated with a small income, and whose period of productivity and higher income is therefore short and concentrated. Present income tax schedules take a large percentage of the income during peak earning years and make it difficult to achieve adequate savings for old age.

Be sure to see or write a letter to your congressman this fall.

The Day In Indiana*

By Maurice Early

*Alcoholism Disease
Indiana To Help
Funds Are Ample
T.B. Heavy Killer*

THIS MONTH Indiana officially entered a new phase of medical treatment and social welfare. By an act of the Legislature, alcoholism is declared to be a disease and state money is appropriated to find ways of taking citizens off of skid row "because they are sick."

TO MOST persons the problem of alcoholism is simple. Just stop drinking. That is the rational thing to do. But throughout the ages, it has been found it is not that simple.

INDIANA'S new commission on alcoholism finds itself with ample funds to make a start. But it is entering a new field. It is not as simple as the fight launched against tuberculosis at the turn of the century.

TO BATTLE TB it was known the weapons largely were diet and rest and now some new drugs are helping. But with alcoholism, something else must be considered. It is a disease of the mind as well as some shortcomings of the body.

AS THE NEW commission, with its headquarters in the Carter Hospital, starts to work, its first

problem is to determine how big a job it faces. Some of the eastern states have made headway which will serve as a guide for the Indiana effort.

HERE ARE some facts about alcohol as it relates to the population of Indiana. Some formulas have been established. They indicate 104,000 adults in the state are drinkers. Of that number the formula indicates 15 per cent are "hard drinkers" and of that number there are 3 per cent alcoholics. Only 38 per cent are listed total abstainers.

FUNDS to carry on the work of the commission comes from a special tax levied seven years ago to help enforcement of liquor laws. It is a small tax, but there is \$780,000 in the fund now. Under the supervision of the budget commission this fund can be drawn upon down to \$250,000.

THERE HAS BEEN so much success in reducing the death rate for tuberculosis that those who fight this plague are worrying about the public becoming complacent. As a killer TB has dropped from first to sixth place. But among the infectious diseases, TB still is first.

IN THE VERY important age group of 15 to 34, TB is listed first among the infectious disease killers.

PROVIDING hospitalization for victims of this disease is still a problem. In Indiana there are as many hospital cases as there were years ago. This does not mean that there is an increase in the number of cases. There are as many cases today as there were years ago simply because there is a big increase in the population.

* The foregoing paragraphs from a recent column by Maurice Early are reprinted with the permission of the Indianapolis Star.



President's Page



FELLOW MEMBERS OF I.S.M.A.:

October, 1953

PRESIDENTS may come and Presidents may go, but may the Indiana State Medical Association exist for many millenniums. The checks and balances provided in its Constitution and By-Laws have proven an excellent method of conducting the business and formulating the policies of this organization. If we continue to adhere to them religiously, all problems which confront the organization will receive ample discussion before solutions are completed and the Oath and Law of Hippocrates will be invoked always with the divine blessing of the American Medical Association.

Our organization functions efficiently in some and inefficiently in other districts, dependent upon the time and interest allotted to it by the respective elected officials. It is evident that many members and members of the Auxiliary to the I.S.M.A. render services constantly "above and beyond the call of duty". "A chain is as strong as its weakest link" and weak links will be replaced with strong ones due to more interest on the part of younger physicians and because of field representatives, like Robert Amick, who liaison our affairs with those of the central office. One has only to look at neighboring state organizations, good as they are, to be proud of both our staff and the set-up of the I.S.M.A. More capable and intelligent management cannot be duplicated. Visit our office, protuberate with its courtesy, and you will depart, exposed to a pleasant affliction known only as Grover-KribsBowmanReiditis. "Hitch your wagon to a star" was exemplified when the Council of the Indiana State Medical Association employed James A. Waggener as Executive Secretary.

And, as this page transsubstantiates itself to my honorable successor, William Harry Howard, M. D., to whom I wish the "best in the west" and to whom you shortly will swear allegiance, I would be remiss not to thank all who have contributed in making the past year multipotent. Space forbids the mention of those who aided and abetted its progress in carrying out assignments and the mention of those who, while perhaps not in harmony with this regime, have remained silent in behalf of harmony and good will. It is regrettable that the Year Book could not have exhibited a replica of all your daguerreotypes, both friend and foe alike. Thus, this year terminates with my sincere appreciation for your toleration, and although about to be a has-been, any latent energy not yet ossified will be at your service in behalf of the noblest of all professions, namely: the art and practice of medicine.

It has been a privilege and a pleasure to serve as your President during 1952-53. This is the ninth organization, of no mean repute, which has relegated the undersigned into the ranks of past presidency, and the descent appears to be the same from each. Anaxagoras once said to a man who was grieving because he was dying in a foreign land, "The descent to Hades is the same from every place." My departing philosophy always formulates this deduction; that the earlier a past president realizes that an organization will be able to operate efficiently without his or her assistance as a "wet nurse", the better off the organization.

Paul D. Grimm M.D.

P.S. Twelve presidential contributions have exhausted my limited supply of B.S. and as future taciturnity cloaks my humble literary efforts with a past president's shroud, herewith is the exodus, as it apologizes to Arthur Guiterman:

"Of all your critical words,
About my tongue or pen,
May the worst be these:
I knew him when."

fr. C. D. (17)

A Letter of Interest:

JOINT COMMISSION *on* ACCREDITATION of HOSPITALS

660 NORTH RUSH STREET, CHICAGO 11, ILLINOIS, MICH. 2-3369

Member Organizations

AMERICAN COLLEGE OF PHYSICIANS
AMERICAN COLLEGE OF SURGEONS
AMERICAN HOSPITAL ASSOCIATION
AMERICAN MEDICAL ASSOCIATION
CANADIAN MEDICAL ASSOCIATION

EDWIN L. CROSBY, M.D.
DIRECTOR

August 31, 1953

Mr. Jas. A. Waggener
Executive Secretary
Indiana State Medical Association
1021 Hume Mansur Building
Indianapolis 4, Indiana

Dear Mr. Waggener:

In reply to your inquiry of August 26, 1953, Bulletin No. 3 and the Standards for Hospital Accreditation are not available presently for distribution in quantity. We shall be pleased to send you twelve copies as soon as these are available.

In reply to your question regarding interpretation of Standard Contingent II E, Department of General Practice, the Commission recommends that general practitioners be granted privileges in the clinical services in the same manner as all other members of the medical staff.

Privileges recommended by the Credentials Committee of the active medical staff and approved by the governing body for all members of the medical staff should be based upon an applicant's training, experience and demonstrated competence. The Commission considers determination of privileges entirely a matter for local determination based upon the above criteria. A general practitioner has complete control over his patients in accord with the privileges granted in the various clinical services.

Your letter will be brought to Doctor Crosby's attention immediately upon his return from San Francisco in Mid-September. Your interest in the accreditation program is appreciated.

Sincerely yours,

John Hinman, M.D.
Assistant to the Director
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104th
Annual Convention

INDIANA STATE MEDICAL ASSOCIATION

October 19, 20 and 21, 1953

French Lick Springs Hotel

French Lick, Indiana

*Complete Program and
Annual Reports on
Following Pages*

Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the French Lick Springs Hotel, French Lick, Indiana, October 19, 20 and 21, 1953.

The House of Delegates will be constituted as follows: Marion County, eighteen delegates; Lake County, six delegates; Allen County, four delegates; St. Joseph County, four delegates; Vanderburgh County, four delegates; Delaware-Blackford, three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Harrison-Crawford, Jasper-Newton, Jefferson-Switzerland, LaPorte, Madison, Owen-Monroe, Parke-Vermillion, Tippecanoe, Vigo and Wayne-Union County Societies, each two delegates; the other fifty-nine county societies, each one delegate; thirteen councilors; and the ex-presidents, namely: C. S. Bond, W. H. Stemm, E. M. Shanklin, Charles N. Combs, George R. Daniels, Charles E. Gillespie, F. S. Crockett, J. H. Weinstein, R. L. Sensenich, Herman M. Baker, Karl R. Ruddell, M. A. Austin, Carl H. McCaskey, J. T. Oliphant, N. K. Forster, Floyd T. Romberger, Cleon A. Nafe, Augustus P. Hauss, C. S. Black, Alfred Ellison, and J. William Wright, Sr.; and ex-officio, the president, president-elect, executive secretary, and the treasurer of the association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the president shall cast the deciding vote.

Blank credentials have been sent by the secretary to each county society, and the properly executed credentials should be mailed to the Indiana State Medical Association, 1021 Hume Mansur Building, Indianapolis 4, Indiana, or brought to the session. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 6:30 p.m., Sunday, October 18, in the west dining room (dinner meeting), and again at 7:30 a.m., Wednesday, October 21, in the west dining room. (Breakfast meeting.)

The order of business will be as follows:

1. Call to order by the president.
2. Roll call and seating of qualified delegates.
3. Reading of the minutes of previous meetings.
4. Appointment of reference committees.
5. Address of president-elect.
6. Report of executive secretary.
7. Report of the treasurer.
8. Report of the chairman of the Council.
9. Reports of councilors.

10. Reports of standing and special committees:

- (1) Executive Committee.
- (2) Board of Appeals on Patient-Physician Relations.
- (3) County Medical Society Officers' Conference.
- (4) Constitution and By-Laws.
- (5) Convention Arrangements.
- (6) Industrial Health.
- (7) Medical Education and Hospitals.
- (8) Public Policy and Legislation.
- (9) Public Relations.
- (10) Publicity.
- (11) Rural Health.
- (12) Subcommittee on Preceptorships.
- (13) Scientific Exhibits.
- (14) Scientific Work.
- (15) Alcoholics Study.
- (16) Anti-National Health Insurance.
- (17) Auditing.
- (18) Cancer.
- (19) Chronic Illness.
- (20) Civil Defense.
- (21) Conservation of Vision.
- (22) Crippled Children Services.
- (23) Diabetes.
- (24) Foot Hygiene.
- (25) Hard of Hearing.
- (26) Heart Disease.
- (27) Indiana Inter-Professional Health Council.
- (28) Infantile Paralysis.
- (29) Instructional Courses.
- (30) Maternal and Child Health.
- (31) Medical Care Insurance.
- (32) Mental Health.
- (33) Military Manpower.
- (34) Necrology.
- (35) Physician-Hospital Relationships.
- (36) School Health and Physical Education.
- (37) State Fair.
- (38) Traffic Safety.
- (39) Tuberculosis.
- (40) Venereal Disease.
- (41) Veterans Affairs and Rehabilitation.
- (42) Liaison Committee with the Indiana Association of Licensed Nursing Homes.
- (43) Liaison Committee with Indiana Department of Public Welfare.

The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the

terms of the following officers expire December 31, 1953, and their successors must be elected at the session: Delegates to the American Medical Association to succeed Karl R. Ruddell, Indianapolis, and Wendell C. Stover, Boonville; and alternates Robert H. Rang, Washington, and Lall G. Montgomery, Muncie.

Delegates from the first, fourth, seventh, tenth and thirteenth districts are reminded that the terms of their councilors will expire December 31, 1953, and the new councilors should be elected to succeed the following:

First District: Herman T. Combs, Evansville.
Fourth District: Charles Overpeck, Greensburg.
Seventh District: Roy A. Geider, Indianapolis.
Tenth District: J. R. Doty, Gary.

Thirteenth District: Kenneth L. Olson, South Bend.

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation.

JAMES A. WAGGENER,
Executive Secretary.

HOUSE OF DELEGATES

Indiana State Medical Association

French Lick, Indiana—October 18-21, 1953

Delegate	Alternate	Delegate	Alternate
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James M. Burk, Decatur		ELKHART	
		S. T. Miller, Elkhart	J. W. Hannah, Wakarusa
		Burton E. Kintner, Elkhart	Floyd S. Martin, Goshen
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E. C. Singer, Fort Wayne	George Buckner,	Connersville	Connersville
G. H. Somers, Fort Wayne	Fort Wayne	H. N. Smith, Brookville	Elmer Peters, Brookville
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			New Albany
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Frank Beardsley, Frankfort	Robert Hedgcock, Frankfort	HAMILTON	
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Glen V. Ryan	Robert D. Pickett
John E. Owen	Wayne Carson
Harry Kerr	Clifford C. Taylor
Don Wolfram	
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NOBLE	
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Delegate	Alternate
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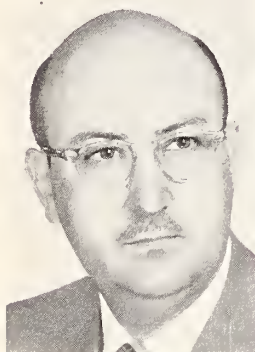
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E. S. Jones, Hammond

Data From Previous Sessions

Year	Session	Place	Registration	Year	Session	Place	Registration
1908	59th	French Lick	312	1930	81st	Fort Wayne	1,115
1909	60th	Terre Haute	421	1931	82nd	Indianapolis	1,033
1910	61st	Fort Wayne	450	1932	83rd	Michigan City	904
1911	62nd	Indianapolis	748	1933	84th	French Lick	637
1912	63rd	Indianapolis	590	1934	85th	Indianapolis	1,814
1913	64th	West Baden	312	1935	86th	Gary	1,011
1914	65th	Lafayette	527	1936	87th	South Bend	1,150
1915	66th	Indianapolis	646	1937	88th	French Lick	1,154
1916	67th	Fort Wayne	381	1938	89th	Indianapolis	1,751
1917	68th	Evansville	270	1939	90th	Fort Wayne	1,332
1918	69th	Indianapolis	388	1940	91st	French Lick	1,064
1919	70th	Indianapolis	---	1941	92nd	Indianapolis	1,890
1920	71st	South Bend	421	1942	93rd	French Lick	706
1921	72nd	Indianapolis	550	1943	94th	Indianapolis	1,323
1922	73rd	Muncie	522	1944	95th	Indianapolis	1,584
1923	74th	Terre Haute	823	1945	96th	French Lick	922
1924	75th	Indianapolis	1,012	1946	97th	Indianapolis	2,240
1925	76th	Marion	800	1947	98th	French Lick	1,618
1926	77th	West Baden	900	1948	99th	Indianapolis	2,681
1927	78th	Indianapolis	1,500	1949	100th	Indianapolis	3,371
1928	79th	Gary	892	1950	101st	French Lick	1,610
1929	80th	Evansville	814	1951	102nd	Indianapolis	2,241
				1952	103rd	Indianapolis	2,649

CONVENTION ARRANGEMENTS



Fitzsimmons

CONVENTION ARRANGEMENTS: Chairman, E. L. Fitzsimmons, Evansville; J. Neill Garber, Indianapolis; Keith Hammond, Paoli; J. A. Davis, Flatrock; Wendell C. Stover, Boonville; R. M. Hansell, Indianapolis; Henry G. Backer, Ferdinand; James H. Crawford, Evansville.

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RECEPTION: Chairman, N. C. Keseric, French Lick, and members of the Orange County Medical Society.

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1952 - 1953

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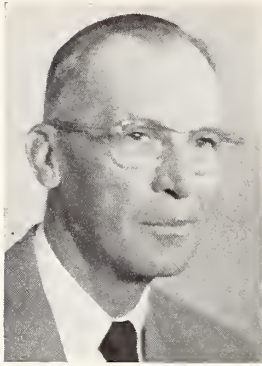
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Evansville

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1952-53



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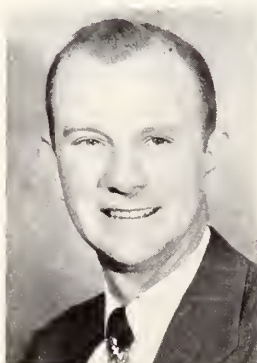
W. L. PORTEUS, M.D.
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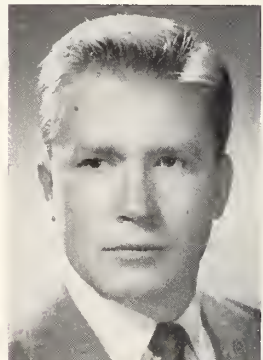
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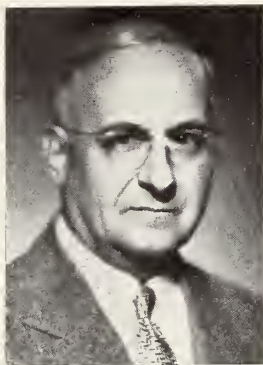
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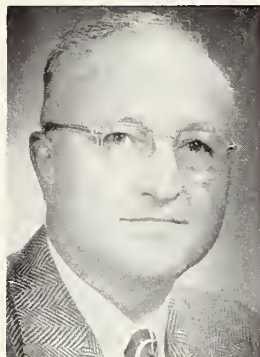
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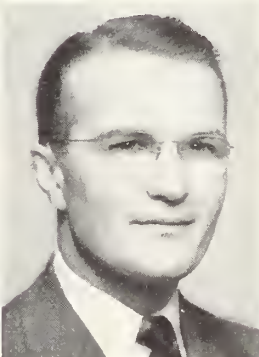
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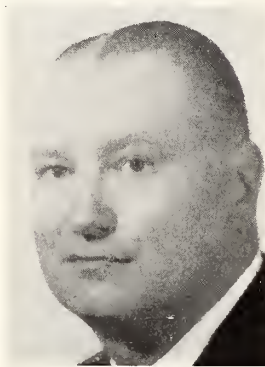
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Koons



Haller



Caylor



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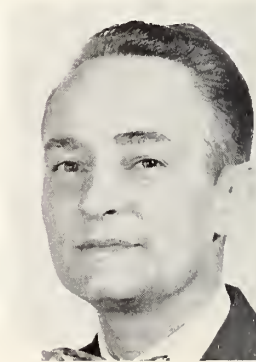
Eisaman



Edwards



Booher

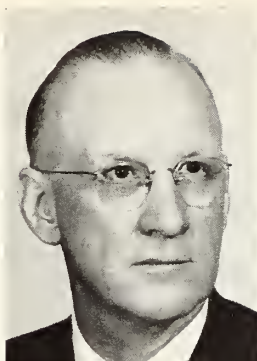


Green

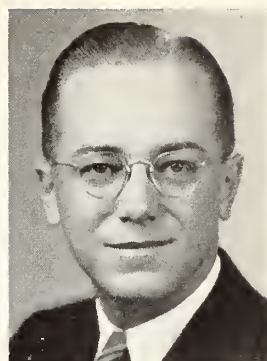
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MacKenzie



Romberger

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Dyar



Craft

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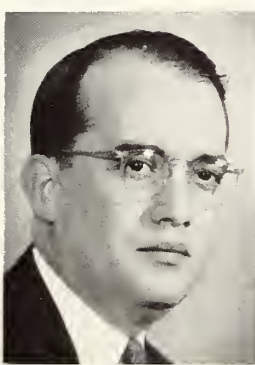
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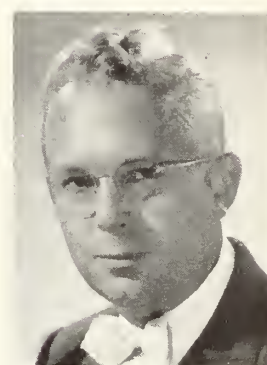
Secretary, V. K. Stoelting, M.D., Indianapolis



Love



Flanigan



Stoelting

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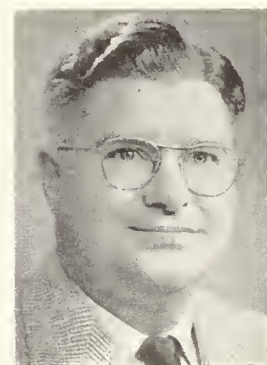
Secretary, L. L. Renbarger, M.D., Marion



McClain



Miller



Renbarger

PROGRAM

104th Annual Convention

INDIANA STATE MEDICAL ASSOCIATION

French Lick Springs Hotel, French Lick, Indiana

October 19, 20 and 21, 1953

Sunday, October 18

- 12 noon Executive Committee meeting, Blue Room.
- 3:00 p.m. Council meeting, Blue Room.
- 6:30 p.m. Meeting of House of Delegates, west dining room. (Dinner meeting).
Invocation, Reverend Thomas G. Scott, pastor, Methodist Church, French Lick.

Monday Morning October 19

- 8:00 a.m. Registration starts, north porch, main floor.
- 8:00 a.m. Opening of technical exhibit, lobby, main floor, and mezzanine floor.
- 8:00 a.m. Opening of scientific exhibit, mezzanine floor.
- 8:00 a.m. Annual golf tournament. Eighteen holes, low gross, low net, and blind bogie medal play. French Lick Hill Course.
- 9:00 a.m. Annual trap and skeet shoot, French Lick Springs Trap and Skeet Club.
- 9:00 a.m. Reference Committees meet.
- 10:00 a.m. Editorial Board meeting, Room 143, main floor.
- 11:00 a.m. Instructional courses.

Monday Afternoon October 19

- 1 to 5 p.m. Instructional courses.
- 2 to 4 p.m. Reference Committees meet.



HENRY L. SCOTT
Concert Humorist*

Monday Evening October 19

- 6:00 p.m. Supper, smoker and stag party, main dining room.
- 8:30 p.m. Entertainment for physicians, wives and guests, main dining room.

* Hilarious virtuoso of the piano—originator of concert humor—Henry L. Scott spreads musical appreciation and hilarity in equal quantities. He'll play a few serious numbers interspersed with boogie woogie and original interpretations. Colliers says "He panics them!" Don't miss hearing him Monday evening.

Tuesday Morning October 20

7:30 a.m. Breakfast meeting of Public Health Officers, Blue Room.

7:30 a.m. Breakfast meeting of Committee on Industrial Health, Parlor A.

8:00 a.m. Registration continues, north porch, main floor.

8:00 a.m. Technical exhibit, lobby, main floor, and mezzanine floor.

8:00 a.m. Scientific exhibit, mezzanine floor.

GENERAL MEETING

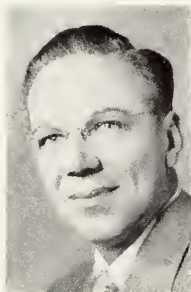
(Main Convention Hall)

10:00 a.m. Call to order by Paul D. Crimm, M.D., Evansville, president, Indiana State Medical Association.

Invocation, Reverend Charles E. Sullivan, S. J., French Lick.

10:05 a.m. Greetings by E. L. Fitzsimmons, M.D., Evansville, chairman, Committee on Convention Arrangements.

10:10 a.m. *"Preventive Measures in Poliomyelitis."*



Hammon

WILLIAM McDOWELL HAMMON, M.D., Professor of Public Health, University of Pittsburgh School of Medicine, Pittsburgh.

10:40 a.m. Panel discussion:

"Physical Defects in Children from Standpoint of General Practice."



Winters



Stauffer

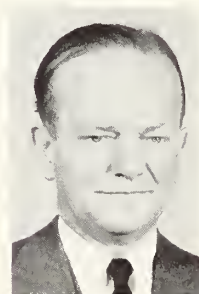
Moderator: MATTHEW WINTERS, M.D., Indianapolis.

Participants:

RICHARD C. STAUFFER, M.D., Fort Wayne (Orthopedic)

MARLOW W. MANION, M.D., Indianapolis (Hearing)

WILLIAM M. COCKRUM, M.D., Evansville (Eye)

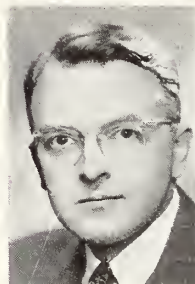


Manion



Cockrum

11:20 a.m. *"Functional Uterine Bleeding."*



Allen

WILLARD M. ALLEN, M.D., Professor of Obstetrics and Gynecology, Washington University School of Medicine, St. Louis.

Tuesday Noon October 20

- 12 m. Phi Beta Pi luncheon, Hunt Room.
- 12 m. Luncheon meeting, class of 1933, Indiana University School of Medicine, Round Room.
- 12 m. Luncheon meeting of Indiana Association of Pathologists, Parlor C.
- 12 m. Luncheon meeting of members of State and County Tuberculosis Committees, Blue Room. Indiana Chapter of American College of Chest Physicians participating.



Bettag

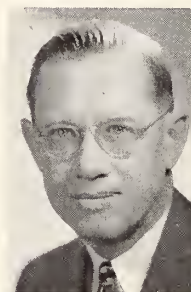
Speaker: OTTO L. BETTAG, M.D., Director, State of Illinois Department of Public Welfare, Chicago.

Subject: "Intra-abdominal Complications and Sequella of Pneumoperitoneum."

Discussion of practice of administering chemotherapy to outpatients. X-ray conference. (Please bring your interesting films.)

- 12 m. Indiana Roentgen Society luncheon meeting, Radio Room.
- Speaker: DAVID G. PUGH, M.D., Rochester, Minnesota.
- Question and answer period.
- 12 m. Luncheon meeting of examiners for Civil Aeronautics Association and members of Aero Medical Association, Parlors A and B. Speaker.

2:30 p.m. "Thrombo-embolic Diseases, Prevention and Management,"



Barker

NELSON W. BARKER, M.D., Professor of Medicine, Mayo Foundation Graduate School, University of Minnesota, Rochester.

3:00 p.m. Intermission to view scientific and technical exhibits.

3:30 p.m. "Roentgenologic Aspects of Arthritis,"



Pugh

DAVID G. PUGH, M.D., Assistant Professor of Radiology, Mayo Foundation Graduate School, University of Minnesota, Rochester.

4:00 p.m. Panel discussion:

"Low Back Pain,"

Tuesday Afternoon October 20 GENERAL MEETING

(Main Convention Hall)

2.00 p.m. "Cardiac Arrest,"



Johnson

JULIAN JOHNSON, M.D., Professor of Surgery, University of Pennsylvania School of Medicine and Graduate School of Medicine, University of Pennsylvania, Philadelphia.



Garceau



Earl

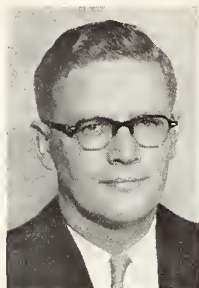
Moderator: GEORGE J. GARCEAU, M.D., Indianapolis.

Participants:

MAX M. EARL, M.D., Kokomo (Medical aspect)

WARREN C. HASTINGS, M.D., Fort Wayne (Neuro-surgical aspect)

LESLIE M. BODNAR, M.D., South Bend (Orthopedic aspect)



Hastings



Bodnar

Tuesday Evening October 20

- 7:00 p.m. President's night, main dining room.
- 8:15 p.m. Address, PAUL D. CRIMM, M.D., Evansville, President. *"Squeeze the Lemon, Let the Juice Squirt Where it May."*
- 8:30 p.m. Entertainment. E. L. Fitzsimmons, M.D., Evansville, chairman.

You'll See:

- * The Harmonica Madcaps—comedy and harmonica duos—Decca artists.
- * The Albins—The Nutmost in Dancing—they've played Winter Garden, Radio City and Latin Quarter, New York.
- * "Sir Richard" Drake—his poker-faced performance called complete entertainment.
- * Professor Backwards—been playing top spots 5 years—recently on Ed Sullivan's TV show.
- * Eddie Burnette and Yvonne—their dancing act is climaxed by "The Fabulous Trunk Escape".
- * The Marguerite deAnguera Dancers—modern dancing by a group of precision trained, beautifully costumed girls.

Wednesday Morning October 21

- 7:30 a.m. Final meeting of House of Delegates, west dining room. (Breakfast meeting). Council meeting immediately following adjournment of House of Delegates.
- 8:00 a.m. Registration continues, north porch, main floor.
- 8:00 a.m. Technical exhibit, lobby, main floor, and mezzanine floor.
- 8:00 a.m. Scientific exhibit, mezzanine floor.

GENERAL MEETING

(Main Convention Hall)

- 11:00 a.m. *"Corticoid Therapy in Dermatology—Its Limitations."*



O'Leary

PAUL A. O'LEARY, M.D., Professor of Dermatology and Syphilology, Mayo Foundation Graduate School, University of Minnesota, Rochester. (Brayton Foundation speaker).

Wednesday Noon October 21

- 12 m. Luncheon meeting of Indiana State Society of Anesthesiologists, Parlors A, B and C, main floor.
- Speaker: ROBERT P. BERGNER, M.D., Professor of Anesthesiology, University of Louisville School of Medicine, Louisville.
- 12 m. Nu Sigma Nu luncheon, Round Room.

SECTION MEETINGS

2:00 p.m. "Endometriosis,"

CARL P. HUBER, M.D., Indianapolis.

Discussion: A. W. Cavins, M.D., Terre Haute.

Obstetrics and Gynecology

12 m. Luncheon meeting, Blue Room.

Vice-Chairman, Pierce MacKenzie, M.D., Evansville

Secretary, Floyd T. Romberger, Jr., M.D., Indianapolis

Moderator: WILLARD M. ALLEN, M.D., Professor of Obstetrics and Gynecology, Washington University School of Medicine, St. Louis.



Huber



Cavins

General discussion.

1:00 p.m. "Amenorrhea,"

SPRAGUE H. GARDINER, M.D., Indianapolis.



Gardiner

* Discussion: C. Curtis Young, Jr., M.D., Evansville. John A. Campbell, M.D., Indianapolis.



Young



Campbell

3:00 p.m. "Prolonged Labor,"

KARL BEIERLEIN, M.D., Fort Wayne.

Discussion: C. O. McCormick, Sr., M.D., Indianapolis.



Beierlein



McCormick

General discussion.

*Each discussor will be given five minutes, following which the discussion will be open to the floor, with Dr. Allen closing the discussion.

General discussion.

4:00 p.m. Election of section officers for 1954.

Wednesday Afternoon October 21

MEDICINE

(North Convention Hall)

Chairman, Richard M. Nay, M.D., Indianapolis.

Vice-Chairman, Paul L. Stier, M.D., Fort Wayne.

Secretary, Jack L. Eisaman, M.D., Bluffton.

2:00 p.m. *"Experience with Mitral Commissurotomy,"*



Close

W. DONALD
CLOSE, M.D., Indi-
anapolis.

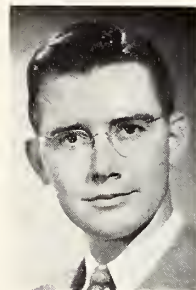
2:30 p.m. *"Management of Acute Thyroiditis,"*



Alderfer

HENRY H. ALDER-
FER, M.D., Marion.

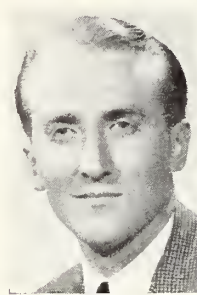
3:00 p.m. *"Treatment of Essential Hypertension,"*



Griffith

RICHARD S. GRIF-
FITH, M.D., Indian-
apolis.

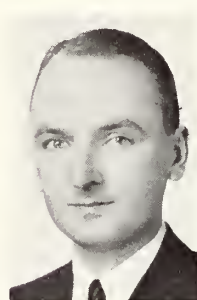
3:30 p.m. *"The Significance and Evaluation of Laboratory Data,"*



Shively

JOHN A. SHIVELY,
M.D., Bluffton.

4:00 p.m. *"Management of Occlusive Peripheral Arterial Disease,"*



Woolling

KENNETH R.
WOOLLING, M.D.,
Indianapolis.

4:30 p.m. Election of section officers for 1954.

SURGERY

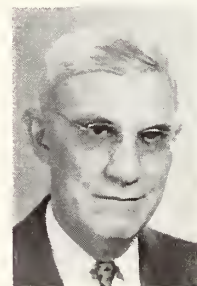
(South Foyer, Convention Hall)

Chairman, Karl M. Koons, M.D., Indianapolis

Vice-chairman, Thomas C. Haller, M.D., Crawfordsville.

Secretary, Truman E. Caylor, M.D., Bluffton.

2:00 p.m. *"Massive Gastro-Intestinal Hemorrhage,"*



Wallace

HAWTHORNE C.
WALLACE, M.D.,
Crawfordsville.

2:20 p.m. Discussion.

2:30 p.m. "Regional Enteritis"



Silver

RICHARD A. SILVER, M.D., Assistant radiologist, Ball Memorial Hospital, Muncie.

2:50 p.m. Discussion.

3:00 p.m. "Cholangiography in Surgery or at the Time of Surgery,"



Caylor

HAROLD D. CAYLOR, M.D., Bluffton.

3:20 p.m. Discussion.

3:30 p.m. "Present-day Cardiac Surgery,"



Thompson

JOHN V. THOMPSON, M.D., Indianapolis.

3:50 p.m. Discussion.

4:00 p.m. Election of section officers for 1954.

OPHTHALMOLOGY AND OTOLARYNGOLOGY

(Hunt Room, Mezzanine Floor)

Chairman, Edwin W. Dyar, M.D., Indianapolis.

Vice-chairman, Kenneth L. Craft, M.D., Indianapolis.

Secretary, Marvin P. Cuthbert, M.D., Indianapolis.

2:00 p.m. "Current Concepts in Orbital Inflammation,"



Keeney

ARTHUR H. KEENEY, M.D., Department of Ophthalmology, University of Louisville, Louisville, Kentucky.

2:30 p.m. "Vertical Muscle Problems,"



Wilson

FRED M. WILSON, M.D., Department of Ophthalmology, Indiana University School of Medicine, Indianapolis.

3:00 p.m. "Surgery of Ménière's Syndrome,"



Brown

DAVID E. BROWN, M.D., Indianapolis.

3:30 p.m. *"Differential Diagnosis of Ménière's Syndrome and Intracranial Tumors,"*



Wright

J. WILLIAM
WRIGHT, Jr., M.D.,
Indianapolis.

4:00 p.m. Messrs. Ted Schlaegel, James V. Fox, Clyde Lorton, James Fowler, Howard White, and Jack Gale will be available throughout the afternoon to discuss lenses and frame fitting.

4:30 p.m. Election of section officers for 1954.

ANESTHESIOLOGY

(Parlors A, B and C, Main Floor)

Chairman. George N. Love, M.D., Indianapolis.

Vice-chairman, Meredith B. Flanigan, M.D., Indianapolis.

Secretary, V. K. Stoelting, M.D., Indianapolis.

2:00 p.m. *"Cardiac Arrest: Some Etiological Factors and the Management of 17 Cases."*
ROBERT P. BERGNER, M.D., Louisville.

3:00 p.m. Election of section officers for 1954.

GENERAL PRACTICE

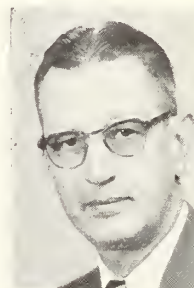
(Main Convention Hall)

Chairman, Bernard E. Edwards, M.D., South Bend.

Vice-chairman, Norman R. Booher, M.D., Indianapolis.

Secretary, Frank H. Green, Jr., M.D., Rushville.

2:00 p.m. *"Doctors and Dollars,"*



Skaggs

ALLISON E.
SKAGGS, Black and
Skaggs Associates,
Inc., Battle Creek,
Michigan.

The general practitioner works hard—handles a lot of money—pays a lot of taxes.

Why should his "overhead" usually be higher than it is?

How much should he save?

Can he work by appointment?

How much office help should he have?

When should he have an associate?

What is his "take-home" pay?

Where do "Public Relations" affect profits?

Mr. Skaggs will present authentic averages compiled by Professional Management field men but not available for publication.

The lecturer will be recognized at once by all who read "Medical Economics". This magazine, during 1952 and 1953, ran a series of articles discussing various aspects of physicians' economic problems.

3:00 p.m. Business meeting and election of section officers for 1954.

3:30 to

4 p.m. Time allowed to view technical and scientific exhibits.

Take time out to visit both the

Technical and Scientific Exhibits

PUBLIC HEALTH AND PREVENTIVE MEDICINE

(Radio Room, Mezzanine Floor)

Chairman, Marvin McClain, M.D., Scottsburg.

Vice-chairman, Minor Miller, M.D., Evansville.

Secretary, L. L. Renbarger, M.D., Marion.

2:00 p.m. *"Epidemiology of Poliomyelitis,"*

WILLIAM McDOWELL HAMMON, M.D.,
Pittsburgh.

2:30 p.m. *"Laboratory Aids in Virus Diseases,"*



Shrigley

EDWARD W. SHRIGLEY, M.D.,
Head of Department
of Microbiology, In-
diana University
School of Medicine,
Indianapolis.

3:00 p.m. *"Summary of Poliomyelitis in Indiana for 1953,"*



Marshall

ALBERT L. MARSHALL, Jr., M.D.,
Director, Division of
Communicable Dis-
ease Control, Indiana
State Board of
Health, Indianapolis.

3:30 p.m. Election of section officers for 1954.

4:00 p.m. Exhibits close.

4:30 p.m. Reception for members of Fifty-Year Club,
Hunt Room, mezzanine floor.

Wednesday Evening October 21

7:00 p.m. Annual dinner and dance, main dining room.

Presiding officer, PAUL D. CRIMM, M.D., President, Indiana State Medical Association.

Invocation, Reverend John Laurence Prentice, pastor, First Presbyterian Church, Paoli.

Recognition of Fifty-Year Club members. Award to Physician of the Year.

Presentation of certificate of merit and plaque to PAUL D. CRIMM, M.D., president 1953, by William Harry Howard, M.D., president, 1954.

9:30 p.m. Dancing. Mark Metcalfe and his band.

WOMEN'S ENTERTAINMENT

Monday, October 19

8:00 a.m. Registration starts, north porch, main floor.

6:30 p.m. Dinner honoring past presidents of the Woman's Auxiliary to the Indiana State Medical Association, west dining room.
Mrs. W. Burleigh Matthew, President, presiding.

8:30 p.m. Entertainment, in conjunction with the Indiana State Medical Association, main dining room.

Tuesday, October 20

8:00 a.m. Registration continues, north porch, main floor.

8:00 a.m. Golf tournament.

10:00 a.m. Board meeting, Woman's Auxiliary to the Indiana State Medical Association, north foyer.

2:00 p.m. Bridge and canasta, north foyer.

7:00 p.m. Entertainment, in conjunction with the Indiana State Medical Association, main dining room.

Wednesday, October 21

8:00 a.m. Registration continues, north porch, main floor.

8:00 a.m. Golf, Flat Course.

1:00 p.m. Luncheon, west dining room.
Paul D. Crimm, M.D., President I.S.M.A., speaker.

7:00 p.m. Annual dinner and dance, in conjunction with the Indiana State Medical Association, main dining room.

Scientific Exhibits

Mezzanine Floor

1. FOOD ALLERGY AND FOOD ADDICTION.

Theron G. Randolph, M.D., Chicago

2. VECTOR CARDIAGRAPH SECTION OF INDIANA HEART FOUNDATION.

Indiana Heart Foundation,
T. A. Kleckner, Executive Director

3. THE ABNORMAL ESOPHAGUS.

M. M. Manalan, M.D.,
Veterans Hospital, Indianapolis

4. MARRIAGE COUNSELING BY PHYSICIAN.

A. P. Hudgins, M.D.,
Charleston, West Virginia

5. HEREDITY OF MULTIPLE BENIGN CYSTIC EPITHELIOMA.

L. Edward Gaul, M.D.,
Evansville, Indiana

6. PHYSICIAN-PHARMACIST RELATIONSHIP.

Indiana Pharmaceutical Association,
Henry W. Heine, Executive Secretary

7. CHOLANGIOGRAPHY.

Caylor-Nickel Clinic, Bluffton
Wallace S. Tirman, M.D.

The 1953 Scientific Exhibits were arranged under the direction of the following standing committee on Scientific Exhibits:

JOHN L. ARBOGAST, M.D., Indianapolis, *Chairman*

SAMUEL L. ADAIR, M.D., Jeffersonville

FRED R. MALOTT, M.D., Converse

J. FRANK MAURER, M.D., Brazil

DALLAS FICKAS, M.D., Evansville

BYRON NIXON, M.D., Farmland

C. TONEY DUTCHESS, M.D., Galveston

J. H. OYER, M.D., Fort Wayne

L. M. MASON, M.D., Terre Haute

Memo to all

I. S. M. A.

members:

This convention has been planned to bring to you the most recent advances in medicine.

You may hear many fine speakers—

You may see outstanding scientific exhibits—

You may visit technical exhibits to learn of new products and new equipment—

You may renew old friendships and make new ones—

Plan now to attend some sessions of the 1953 Convention of the Indiana State Medical Association!

Reports of Officers

THE EXECUTIVE SECRETARY

The past year has seen many advancements and changes in the activity of your state office. The work load has not decreased but has materially increased as many of the committees were more active and many new programs were placed in operation.

As this House meets to consider the activities of the Association during the past year, and reviews the work carried on through your headquarters office, your staff hopes the responsibilities assigned it have been carried out in the proper manner.

The President, the executive committee, the council and the various committees of the Association have contributed much to the success of the Association during the past year. All have given willingly of their time, and have worked enthusiastically as a team in bringing your Association and its programs to a high degree of success. It has been a sincere pleasure for your entire staff to have had the privilege of working so closely with men so interested in their organization.

It is not the intent here to go into detail concerning the many activities of the Association, but I would like to call your attention to several of the programs being carried on through the various committees.

Your conventions have reached a new high in popularity not only with the membership, but also with the exhibitors. Last year's meeting saw a new high in attendance, and the cooperation of the members in visiting the various exhibits brought Indiana new recognition from the exhibitors of the nation. In fact, as proof of this, at this very meeting, you will note many new exhibitors, and you will also see the largest exhibit ever held at a French Lick meeting of the Association. The income from this convention for exhibits nearly reaches the amount received during an Indianapolis meeting. Due to the lack of space at French Lick, we were forced to turn down many of our friends who have been with us in the past because they were a little late in sending in their reservation request. You might be interested in knowing, that the invitation to exhibitors for this meeting went out in March, and by noon of the day established for taking orders for space we were sold out.

I would urge this House to take special recognition of the exhibitors and the quality of their exhibits. I hope every member of the Association will take the time to visit the exhibits, and talk to the man in charge, letting him know how much you as a member of the House appreciate his being there. If we can make them feel at home, feel wel-

come in our midst, it goes without saying that word will be passed along, "don't miss making the Indiana Convention, Indiana physicians really appreciate your being there." This is all that is necessary to build our exhibit in quality and quantity to second to none in the country.

During the past year, I have had the pleasure of attending as an invited guest some of the state meetings of our neighboring state associations. It has been interesting to note the emphasis they place on scientific exhibits, much more than we here in Indiana, where they originated.

It has been my observation that the scientific exhibits in the other states have been successful in drawing a very large participation not only from physicians throughout the country who have prepared the exhibits, but also from the membership of the state as well.

The reason behind our failure to place more emphasis on the scientific exhibits is unknown to your secretary. It may be that space has been a factor, or that the expense has been the reason we have apparently held our exhibits to a minimum. If we are successful in increasing our technical exhibits, perhaps it might be well to consider appropriating some of our income from the sale of space into funds for use in enlarging our scientific exhibits.

Medical Education Foundation

It was gratifying to every physician in the Association to note in the annual report of the American Medical Education Foundation that Indiana led the nation in total contributions to this fund last year. Twelve hundred and seventeen Indiana physicians contributed \$58,152.54 to the fund during the year 1952. This is a remarkable record of the efforts of your committee and the interest and loyalty of the members of the Indiana State Medical Association.

Legislative

Your Committee on Public Policy and Legislation experienced one of the most difficult times in years during the session of the 1953 State Legislature. You will find their report in detail elsewhere, but I would like to call your attention to the hours of work put in by this committee in behalf of the membership of the Association. Attendance at committee hearings alone was almost a daily routine. While they were successful in their efforts to procure the most favorable legislative program possible for the medical profession, I believe, if you will talk to any member of the committee he will finally admit the problems of

the last session were much greater than in past years.

Public Relations

This year, if the House approves the report of the Committee on Public Relations, it marks the first time that an attempt has been made to put down on paper a state-wide public relations program and suggested outline for individual physicians and the component societies to follow. This I am sure you will agree is a great step forward.

Physician Placement

Another first has been brought to Indiana during the past year through the efforts of your Committee on Rural Health. The new physician placement service which has been organized by this committee is recognized as one of the most complete in the nation. Such a favorable impression has been created that the American Medical Association requested copies for forwarding to all other states, holding the Indiana plan as a model. Inquiries from publications, national in circulation, indicate you may be reading of this service before long in these publications.

In August your headquarters office had a visitor, a physician just out of military service, coming direct to Indiana from Germany following his discharge. The reason he gave for coming to Indiana was that he had requested information from various states on available openings, but was so impressed with the information contained in the Placement Service booklet that he came to Indiana. He further stated he had shown the booklet to his friends in Germany, which probably explains why we have had additional requests for information on Indiana openings from physicians now in service. It may also be of interest to you to know that this booklet was displayed by the AMA during their recent annual meeting in New York.

The past year has also seen the formal organization of the Indiana Foundation for Community Health, the organization proposed by the Rural Health Committee and approved by this House some two years ago.

There are, of course, many other committees that should be mentioned here but their reports, as you read them, will give you a detailed study of the activities of your Association during the year.

Looking Ahead

Looking ahead to the coming year, one can see many matters of great importance to the profession which will come up for decision.

The 1955 legislative session promises to be one of many problems. We know today the chiropractors will be with us again, perhaps more strongly organized than ever before. This issue appears to be headed for congressional action, too, especially in regard to the VA accepting the chiro for treatment of servicemen.

We have been forewarned that labor will introduce an entirely new workmen's compensation bill which will propose changes in the medical care in compensation cases.

It appears that the coming year will be one of decision for those in the hospital and medical care insurance field. Increasing costs have skyrocketed hospital charges and, in turn, insurance premiums until many feel the premium structure has about reached the saturation point. Even some in industry are beginning to hold the view of labor that more comprehensive programs are a must. There is no doubt that many insurance companies will begin a readjustment program, but the unfortunate part of it is, the physician, while his fees have not increased in proportion to other costs of illness, is still receiving the blame for the high cost of sickness. This alone, it would seem should amplify the necessity of our reevaluation of our public relations at all levels.

Many new programs will come into being during the coming year, the field service will be stepped up, additional publications are planned by some of the committees, and expenses will in all probability rise, if these various programs as contemplated are carried on to completion.

Other Activities

Your secretary, in company with the President visited the District meetings, and has visited with many individual physicians. In May of this year, I was invited to address the Illinois State Medical Association meeting on Public Relations and have taken part in the Public Relations Institute of the American Medical Association.

The Journal

Several improvements have been made in THE JOURNAL during the past year: a new attractive cover; new make-up style has been instituted to improve the reading quality; and the advertising format has been rearranged to encourage more use of THE JOURNAL by the advertisers. ;

In reviewing the financial structure of THE JOURNAL for the full years available at the time this report was prepared, a comparison has been drawn between the last six month period of 1951 and the first six month period of 1952, and comparing them with the last six months of 1952 and the first six months of 1953 and it is noted that while THE JOURNAL is not a moneymaking venture for the Association the loss for the period last year was reduced \$2,246.67 over the same period the year before. For the 1951-52 period our loss was \$4,061.31 as compared to \$1,814.64 for the period of 1952-53.

Additional emphasis is being placed on the procuring of advertising and it is hoped that within another year THE JOURNAL can be brought to a break-even point.

Jas. A. Waggener,
Executive Secretary

Since the report of the accountants as of December 31, 1952, surpluses in the General Fund have been invested in U. S. Government Securities.

On January 6, 1953, \$30,000.00 was invested in U. S. Treasury Certificates of Indebtedness. These securities earned 1½% and matured June 1, 1953. This \$30,000.00 was reinvested in U. S. Treasury Certificates of Indebtedness, Series B. These securities earn 2½% and mature June 1, 1954.

On July 23, 1953, \$60,000.00 was invested in 3¼% U. S. Treasury Bonds.

The bank balance in the General Fund, Medical Defense Fund, The Journal Fund and Petty Cash Fund as of July 24, 1953 may be found in the report of the Auditing Committee.

The following is a detailed report prepared by Geo. S. Olive & Co. of Indianapolis, showing the financial status of the association as of December 31, 1952.

ROY V. MYERS, M.D., *Treasurer.*

January 27, 1953.

The Council,

Indiana State Medical Association,
Indianapolis, Ind.

Gentlemen:

We have examined the accounts and financial records of the Indiana State Medical Association as of December 31, 1952, and the statements of income and expense and fund balances for the year then ended, on a cash receipts and disbursements basis. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying statement of assets, all funds, and related statements of income and expense, on a cash receipts and disbursements basis, present fairly the position of the Indiana State Medical Association at December 31, 1952, and the results of its operations for the year then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Yours very truly,

GEO. S. OLIVE & Co.,
Certified Public Accountants.

INDIANA STATE MEDICAL ASSOCIATION	
Analysis of Increase in Assets, All Funds.	
Year Ended December 31, 1952	
TOTAL ASSETS, DECEMBER 31, 1952—ex-	
hibit B -----	\$174,728.37
TOTAL ASSETS, DECEMBER 31, 1951-----	119,223.28
NET INCREASE -----	\$ 55,505.09
Arising from the following sources:	
Excess of operating cash	
receipts over operating	
cash disbursements,	
year ended December 31,	
1952:	
General fund—exhibit C:	
Receipts ---	\$142,465.34
Disburse-	
ments ---	113,731.34
	28,734.00
Add: Pur-	
chase of	
bonds ---	35,000.00
	\$63,734.00
The Journal of	
the Indiana	
State Medi-	
cal Associa-	
tion — ex-	
hibit D:	
Receipts --	39,374.21
Disburse-	
ments ---	48,980.02
	(9,605.81)
Medical De-	
fense fund—	
exhibit E:	
Receipts ---	4,827.55
Disburse-	
ments ---	4,450.65
	376.90
Add: Pur-	
chase of	
bonds ---	1,000.00
	1,376.90
NET INCREASE -----	\$ 55,505.09

Exhibit B	
INDIANA STATE MEDICAL ASSOCIATION	
Statement of Assets, All Funds, at December 31, 1952	
GENERAL FUND:	
Cash on deposit—Exhibit C---	\$69,449.55
Petty cash fund -----	1,000.00
Investments:	
U. S. Treasury	
bonds -----	\$ 5,000.00
U. S. Savings	
bonds -----	71,000.00
	76,000.00
Total General Fund -----	\$146,449.55

THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION:

Cash on deposit—Exhibit D--- 4,960.47

MEDICAL DEFENSE FUND:

Cash on deposit—Exhibit E--- 4,318.35

Investments:

U. S. Treasury
bonds ----- 5,000.00U. S. Savings
bonds ----- 14,000.00

19,000.00

Total Medical Defense Fund 23,318.35

TOTAL ASSETS, ALL FUNDS—Exhibit A \$174,728.37**Exhibit C****INDIANA STATE MEDICAL ASSOCIATION****Comparative Statement of Cash Receipts and Disbursements, Years Ended December 31, 1952, and December 31, 1951****GENERAL FUND**

	Year Ended Dec. 31, 1952	Dec. 31, 1951	Increase (Decrease)
--	--------------------------------	------------------	------------------------

**CASH BALANCE
AT
BEGINNING OF**

YEAR -----	\$40,715.55	\$ 5,533.51	\$35,182.04
------------	-------------	-------------	-------------

RECEIPTS:

Membership dues - 115,850.00 115,370.00 480.00

Income from

exhibits ----- 14,316.00 14,675.00 (359.00)

Interest income -- 1,507.50 1,172.50 335.00

Proceeds from ma-
tured bonds ----- 4,000.00 (4,000.00)Egbert Scholarship
fund ----- 100.00 200.00 (100.00)Centennial book
fund ----- 2.50 14.45 (11.95)Miscellaneous in-
come ----- 14.00 (14.00)Instructional
courses ----- 689.34 ----- 689.34Transferred from
The Journal of
the Indiana State
Medical Associa-
tion ----- 10,000.00 ----- 10,000.00

Total receipts

—Exhibit A—\$142,465.34 \$135,445.95 \$7,019.39

**BEGINNING BAL-
ANCE PLUS CASH****RECEIPTS** ----- 183,180.89 140,979.46 42,201.43**DISBURSEMENTS:**Transfer of appli-
cable portion of
dues to The Jour-
nal of the Indiana
State Medical As-
sociation ----- 11,019.00 10,896.00 123.00Medical Defense
fund—Exhibit E_ 4,348.75 4,318.75 30.00Purchase of
securities ----- 35,000.00 4,000.00 31,000.00Headquarters'
office expense -- 26,726.12 21,155.03 5,571.09

Publicity

committee ----- 906.88 1,703.55 (796.67)

Public policy ----- 1,608.29 2,374.83 (766.54)

Council ----- 1,480.84 1,563.46 (82.62)

Officers ----- 2,712.09 1,893.40 818.69

Annual session --- 13,164.98 11,800.25 1,364.73

Standing

committees ----- 5,957.07 3,170.73 2,786.34

Special committees 2,929.68 5,814.48 (2,884.80)

Federal insurance

contributions tax 239.77 242.37 (2.60)

Indiana unemploy-
ment compensa-
tion and excise

tax ----- 431.92 421.31 10.61

Fifty-year club --- 245.04 324.08 (79.04)

Increase in petty

cash fund ----- 500.00 (500.00)

Woman's Auxiliary

to I.S.M.A. ----- 298.77 77.13 221.64

General practitioner

award ----- 476.04 58.46 417.58

A.M.A. Coordinat-

ing Committee -- 6,186.10 -29,950.08 (23,763.98)

Total disburse-

ments—Exhibit

A ----- 113,731.34 100,263.91 13,467.43

CASH BALANCE AT**END OF YEAR** --\$ 69,449.55 \$ 40,715.55 \$ 28,734.00**Exhibit D****INDIANA STATE MEDICAL ASSOCIATION****Statement of Cash Receipts and Disbursements,
Year Ended December 31, 1952****THE JOURNAL OF THE INDIANA STATE
MEDICAL ASSOCIATION****BALANCE, JANUARY 1, 1952** --- \$14,566.28**RECEIPTS:**

Subscriptions—members—

Exhibit C ----- \$11,019.00

Subscriptions—non-members ----- 469.50

Advertising ----- 27,139.45

Collections on accounts receivable 445.78

Single copy sales ----- 152.50

Electrotypes ----- 29.84

Sale of civil defense reprints ----- 48.35

Miscellaneous ----- 69.79

Total receipts—Exhibit A----- 39,374.21

53,940.49

DISBURSEMENTS:

Salaries ----- 8,298.13

Printing ----- 26,563.85

Office postage ----- 258.30

Journal postage ----- 640.55

Advertising commissions ----- 167.86

Electrotypes ----- 956.58

Press clippings ----- 120.20

Office supplies ----- 570.38

Rent ----- 480.00

Electricity ----- 32.27

Telephone and telegraph ----- 241.06

Federal insurance contributions-- 124.08

Indiana unemployment compensa-

tion and excise ----- 248.19

Art work ----- 88.27

Transfer to general fund ----- 10,000.00

Miscellaneous ----- 190.30

Total disbursements—

Exhibit A ----- 48,980.02

BALANCE, DECEMBER 31, 1952—Exhibit B \$4,960.47

Exhibit E

INDIANA STATE MEDICAL ASSOCIATION
Statement of Cash Receipts and Disbursements,
Year Ended December 31, 1952

MEDICAL DEFENSE FUND

BALANCE, JANUARY 1, 1952 -----	\$3,941.45
RECEIPTS:	
Transfer of applicable portion of dues from the general fund—Exhibit C -----	\$ 4,348.75
Interest income -----	478.80
 Total receipts—Exhibit A ----	 4,827.55
	<hr/> 8,769.00
DISBURSEMENTS:	
Malpractice fees -----	1,475.00
Attorney fees -----	1,882.50
Treasurer's bond -----	37.50
Purchase of U. S. Savings bond --	1,000.00
Miscellaneous -----	55.65
 Total disbursements—Exhibit A	 4,450.65
	<hr/>
BALANCE, DECEMBER 31, 1952—Exhibit B	\$4,318.35

CHAIRMAN OF THE COUNCIL

The past year has been indeed a busy one for the members of the Council and we hope it has functioned as intended as a clearing house for the many proposals that come before it in the course of a year.

Copies of resolutions to be introduced in the House of Delegates meetings and the agenda of the Council meetings have been gotten out to the Councilors, and they in turn for the most part have contacted their constituent county societies, with the result that one no longer hears what was formerly current among our members, viz., "We don't know what's going on in the Council or at the Headquarters Office."

The Indiana Medical Foundation authorized by the Council continues to do good work in the accumulation of funds for medical education in general and our own Indiana University School of Medicine in particular. Dr. J. W. Denny is to be commended for the impetus and able leadership he supplied for this worthy movement. Receipts at last report totalled \$82,761.59 with Indiana University receiving \$37,462.97. While the 1953 check had not been received at the time of writing this report. I. U. has so far received a total of \$62,390 from the fund. Remember, you can designate where your gift goes, but give!

Matters referred by the Council to the House of Delegates of last year's (1952) convention and the action taken were as follows:

1. Resolution amending the Constitution abolishing the office of Alternate Councilor. The Council reversed its position on this, first voting for and then against it. Did not pass the House of Delegates.

2. Resolution concerning the reduction of dues of the Indiana State Medical Association. The

Council recommended that this not be passed—that the dues remain the same for 1953. This was upheld in the House of Delegates.

3. Resolution concerning the establishment of preceptorships. Recommended by the Council to pass and did.

Matters presented by the Council to the interim session of the House of Delegates and the action taken were as follows:

1. The Indianapolis Medical Society resolution in regard to P. L. 779 (Doctor Draft Act) urging that every effort be made to revise it to make its constitutionality above reproach or to test its constitutionality if passed in its present form was passed with a few changes in wording.

2. Resolution regarding the better use of fees paid for medical licensure was passed. Since then a letter has been received from the Governor's office in regard to the use of these fees.

3. Resolution regarding malpractice insurance rates in partnerships. Passed.

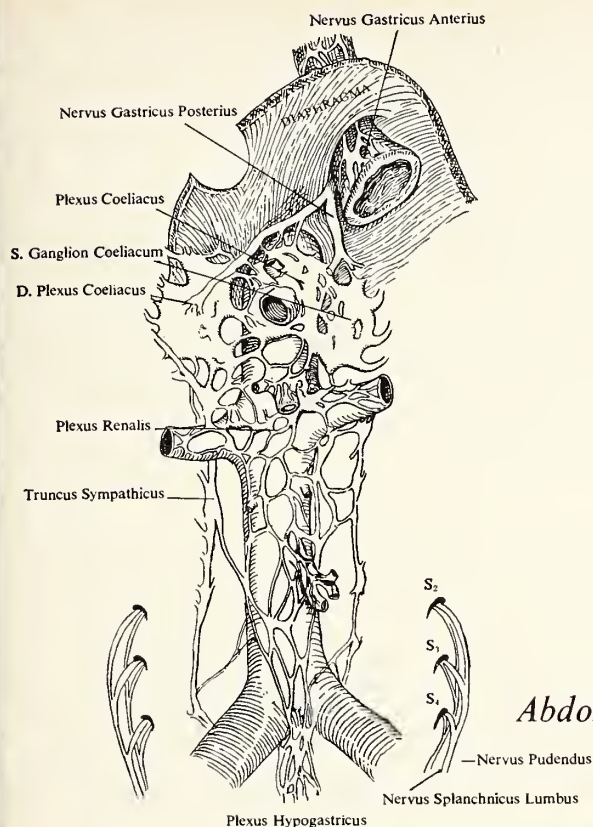
4. Decision was made not to hold the 1954 convention in Fort Wayne as previously planned.

5. Resolution about the interim meetings as to whether they should continue. It was voted to refer this back to the individual county societies as a referendum. Although all have not been heard from, preliminary report seems to indicate that most voted to discontinue the interim sessions.

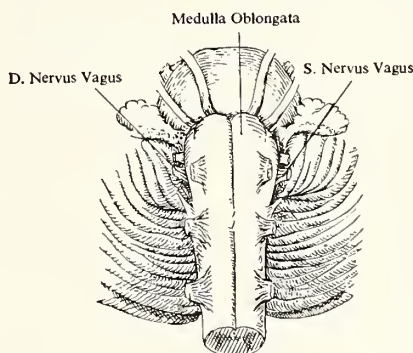
6. The report of Dr. Lester D. Bibler's Subcommittee on Preceptorships was accepted by the House of Delegates and final approval was to be given by the Council of the Indiana University School of Medicine. It is my understanding that this has been done and that the actual plan will be put into operation this September. In reality a few trials were made of the plan in the Indianapolis area this past year.

The Council adopted Dr. Frank B. Ramsey's suggestion about the election of three additional associate editors for THE JOURNAL, and they were elected as follows: Drs. Stephen Johnson of Evansville, Lall G. Montgomery of Muncie, and David A. Bickel of South Bend.

Changes in the personnel of the Council the past year were: 6th Dist.—Election of Dr. Harry P. Ross of Richmond as Alternate; 8th Dist.—Election of Dr. T. R. Hayes of Muncie, formerly Alternate, as Councilor replacing Dr. F. E. Keeling, resigned, and of Dr. Gordon B. Wilder of Anderson as the present Alternate; 10th Dist.—Election of Dr. J. R. Doty, Gary, replacing President-Elect Dr. W. H. Howard as Councilor from his previous office of Alternate, and the filling of that vacancy by Dr. James P. Vye of Gary; 12th Dist.—Dr. Otto Lehmberg of Columbia City replaced Dr. Myron L. Habegger as Alternate, and recently, Dr. M. B. Catlett of Fort Wayne resigned as Councilor, and has been replaced by Dr. Maurice E. Glock, Fort Wayne.



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It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

1. Zupko, A. G.: Pharmacology and the General Practitioner, GP 7:55 (March) 1953.

2. McHardy, G. G., and Others: Clinical Evaluation of Methantheline (Banthine) Bromide in Gastroenterology, J.A.M.A. 147:1620 (Dec. 22) 1951.

SEARLE Research in the Service of Medicine

A resolution for a uniform fee schedule for medical and surgical services with the Indiana Department of Public Welfare was approved, and a committee appointed to meet with the Welfare Department to see what could be arranged. This committee has met with the Board and had a very satisfactory conference, so that as a matter of fact the Welfare Department wishes a Liaison Committee continued. In making inquiries among the various county societies, however, Mr. Amick, the Field Secretary, reports that opinion is greatly divided as to whether they, in fact, want such uniform rates established.

Some significant decisions made by the Council in a lengthy session, July 19, were:

Dr. J. E. Dudding presented a County Medical Forum Plan, which was approved.

The question of hospital accreditation was brought up with reference to possible discrimination against the general practitioner in the departmentalizing of hospitals to meet requirements. Referred to committee.

Why Indiana does not recognize the National Board of Medical Licensure was discussed and referred to committee.

The Council went on record as favoring the Jenkins-Keogh bills (H. R. 10 and 11) and urges the members to notify the Senators and their Congressmen of their opinion of these bills.

It was voted to approve in principle H. J. Resolution 123 a resume of which was presented by Dr. James L. Doenges. This is a proposed amendment to the Constitution of the United States, relative to prohibiting the United States Government from engaging in business in competition with its citizens.

A suggestion from the Board of Appeals in regard to medical testimony to appoint a committee to handle such cases and complaints was approved.

The perennial motion for amending the Constitution of the state society to allow the election of a Vice-President or Speaker of the House or both was rejected.

The suggestion made in an A.M.A. resolution to refer to each state society the question of asking each member to pay \$20.00 per year to the American Medical Foundation Fund was rejected, it being felt that such payments should be kept on an optional free-will offering basis.

It is felt that the new plan inaugurated in the Council of having standing committees to which various proposals can be referred in advance will aid us in the better evaluation thereof.

ELTON R. CLARKE, M.D., *Chairman.*

Reports From District Councilors

FIRST COUNCILOR DISTRICT

Activity was well above the usual in the first district for 1952.

The Hospital situation at Tell City has been ironed out.

The Vanderburgh County group had an excellent Post Graduate Program besides many other good speakers at regular meetings. The public relations program which was stressed through labor organizations was well received.


H. T. COMBS, M.D., *Councilor.*


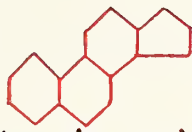





SECOND COUNCILOR DISTRICT

At the last annual meeting your Councilor gave all possible assistance from the floor on discussions of cutting out non-service-connected (N-S-C) disabilities from Veteran's hospitalization programs to the end that the House of Delegates would ratify the excellent recommendation of Dr. Wm. H. Garner's Committee on Veterans' Affairs. Since there were many discussants who lacked courage for a definite stand on an obvious evil, a compromise was made in the form of liaison meetings with the Veterans organizations and other interested groups. Despite the fact that basic issues concerning P.L. 312 were not discussed at such liaison gatherings during subsequent months, the AMA delegates in June did eventually recommend "half a loaf of bread" toward freedom's goal when they went on record as being against federal care of N-S-C disabilities except NP & TB cases. The latter slices the bread to much less the "half a loaf" because it comprises about 45% of the 66% of admissions to Veterans Hospitals that are N-S-C. There was no prominent suggestion that the NP's and TB's be reverted to local care just as fast as possible!

No action was taken by the ISMA on your councilor's accepted resolution for concerted grass roots action on Section 3, P.L. 590 because the AMA advised our state organization that the law would expire. Just how there was a secret tie-up between our medical association officers and administration that proved this to be true is not comprehended by the writer. Yet the law expired to be replaced by bills for similar legislation that are now in the hopper!

It should be recorded that your Councilor was not in favor of a change in the existing state laws to permit workingmen a free choice of a doctor as long as their employer was paying for the doctor. He who pays shall rightly designate! The proposed bill did not pass our State Assembly.

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Because of the action of the special meeting of AMA delegates in March 1953, your councilor introduced two resolutions at our April interim meeting. One was a sharp criticism of the AMA sponsoring the elevation of the socialist F.S.A. to cabinet status. The other was related to that same action by virtue of its inquiry into what our excess dues were being spent for to permit such an illogical action after receiving support from other American minded organizations a few years previous. Neither resolution passed the House of Delegates. Yet, with all the speed and urgency of the delegates to the AMA favoring a cabinet status for Mrs. Hobby—the special health secretary was appointed in August. Our District Meeting at Bloomington in June was most successful under the able direction of Doctor Ramsey and his co-workers. Any elements lacking in the business session were made up for by the excellence of the discussion of lung cancer by the panel which participated for the scientific part of the program and which was capped during the banquet by Doctor Crimm's stimulating address.

Finally, at the July meeting of the Council, your representative assisted in the passage of a resolution to favor a trial of Dr. Van Nuy's plan for permitting faculty members of the College of Medicine to do private practice so long as it did not interfere with teaching duties; a resolution to favor H.J. Res. 123 which would provide an amendment to the Constitution of the U.S.A. prohibiting the federal government from participating in business activities that should be handled by private enterprise; and a resolution favoring the Jenkins-Keogh Bill for tax deferment of a percentage of current professional income for the purpose of establishing a retirement fund.

A. G. BLAZEY, M.D., *Councilor*.

THIRD COUNCILOR DISTRICT

We in the Third District are busy with the complicated practice of medicine and surgery. Our annual meeting was held at French Lick in June. It was well attended and three excellent papers were presented. We had our social dinner meeting in the evening. We were fortunate to have the Secretary of State Association and our Field Secretary and President of the Woman's auxiliary.

We regretted very much that the President of our Association had such pressing business not to attend our dinner meeting. We will meet next spring at Jasper, Indiana.

The Floyd County Memorial Hospital has recently been opened in New Albany. This makes three new hospitals in last few years in this

District. One at Corydon, one at Salem and this one in New Albany.

WM. H. GARNER, M.D., *Councilor*.

FOURTH COUNCILOR DISTRICT

The Forty-ninth Annual Assembly of the Fourth Medical District of Indiana was guest of Bartholomew County doctors and met May 6, 1953 at Harrison Lake Country Club.

The Golfers had their morning in a tournament with approximately twenty golfers struggling for trophies.

The House of Delegates met near noon and transacted the business of the assembly and elected the following officers for next year:

Dr. Joseph Black, Seymour, president

Dr. George Row, Osgood, vice president

Dr. C. A. Weithoff, secretary and treasurer.

By unanimous consent Dr. Joe Dudding, Hope, was made Councilor for three years beginning January 1, 1954.

The scientific session was informative and interesting. The discussion of "Management of the Painful Shoulder" by Dr. Chas. Herndon, "Pitfalls in Cardiac Diagnosis and Treatment" by Dr. John Martin and "Thoracic Surgery" by Dr. Wayne Carson were simply yet masterfully handled.

The meeting is invited to Seymour for 1954.

CHAS. OVERPECK, M.D., *Councilor*.

FIFTH COUNCILOR DISTRICT

The Fifth District Medical Society met on May 13, 1953 at Brazil at the invitation of the Clay County Medical Society. Dr. Robert Webster presided. Arrangements were handled by the Clay County Secretary, Dr. John Palm, and left nothing to be desired. The scientific portion of the program was opened by an address by Dr. James Bowman of Indianapolis on "Gamma Globulin in Poliomyelitis"; Dr. Frank Teague of Indianapolis spoke on "Common Disorders of the Feet" and Dr. Donald W. Brodie of Indianapolis spoke on "Alcoholism." The scientific session was followed by a delicious dinner served at the Elks Club. Officers for the coming year were elected as follows: President—Dr. S. R. Combs of Terre Haute; Secretary—Dr. Cleon M. Schauwecker of Greencastle.

The 1954 meeting will be held at Terre Haute.

M. C. TOPPING, M.D., *Councilor*.

SIXTH COUNCILOR DISTRICT

The Sixth District has had no outstanding incidents in the past year. Hospital construction is practically completed, leaving only two counties

without hospitals, both being adequately supplied by adjoining counties, which include the profession of the smaller counties on their staffs so that adequate service is available and near. The improved standards of service are reflected in the general public service lessening and practically obliterating any public demand or need for Federal help.

Without exception, the various welfare boards have, in consultation and with the approval of the county medical societies, set up adequate medical programs. Health departments, both city and county, are adequately handling community health matters, removing need or demand for rural full time departments.

The profession has welcomed some new and younger practitioners, the number being sufficient to compensate losses by retirement or death. Special efforts are made to interest these younger men in the official activities of the District.

The annual meeting at Connersville in April successfully tried a new form of program by having a small but distinguished group present a short program followed by a long panel discussion. Dr. H. P. Ross, retiring president, was named alternate councilor, Dr. R. W. Kuhn of Wilkinson and Dr. J. E. Fisher of New Castle moved automatically to president and vice-president, and Dr. Wm. R. Tindall of Shelbyville became secretary. President Crimm honored the society by a visit and a grace-

ful talk. The councilor, Doctor Kennedy, discussed the national political outlook based on a recent Washington visit and also presented a review of the year's activity in Blue Shield.

The Woman's Auxiliary of the district met at the same time and joined in the dinner.

Attendance was over 100.

WALTER U. KENNEDY, M.D., *Councilor*

SEVENTH COUNCILOR DISTRICT

The Seventh District has had two very fine meetings during the past year and at this writing, is looking forward to another meeting just prior to the Annual Convention of the Indiana State Medical Association.

On October 22, 1952, Johnson County Medical Society was our host at Franklin. One hundred and thirty-five physicians, their wives and guests were in attendance. While the women heard a talk on interior decorating, the men played golf. Dr. Wm. D. Province, Franklin, presided at the general meeting. Dr. Elmer L. Koch, Danville, was named president-elect and Dr. T. V. Petranoff, Indianapolis, was chosen secretary-treasurer. Everyone enjoyed an excellent dinner in the evening at Franklin College. Mr. William Alan Richardson, editor of *Medical Economics*, East Rutherford, N.J., gave an after-dinner address.



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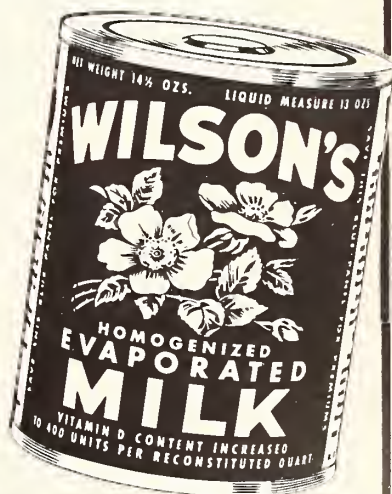
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The 1953 Spring meeting of the Seventh District was held the evening of May 27 in the Athenaeum in Indianapolis with 143 members, their wives and guests present. Dr. Ralph V. Everly, District President, presided and introduced the various county society officers. A plaque was presented by the Indianapolis Medical Society to Mr. Edward F. Gallahue, Indianapolis insurance executive, for his guidance and financial support to the medical division of the \$12,000,000 campaign for additional hospital beds in Indianapolis. This presentation was made by Dr. Lawson J. Clark, chairman of the campaign's medical division. Principal address of the evening was given by Dr. I. Lynd Esch, president of Indiana Central College, who discussed salesmanship as it is related to the medical profession. It was the opinion of Dr. Esch that the profession, while it has the best medical product to sell that the world has ever known, sometimes does a poor job in salesmanship with resultant bad public relations.

The Seventh District will meet again this fall in Indianapolis on Oct. 14th.

ROY A. GEIDER, M.D., *Councilor*.

EIGHTH COUNCILOR DISTRICT

The Eighth District held its annual meeting at the Delaware Country Club on May 20, 1953. The afternoon was devoted to social activities, the more athletically inclined played golf at the club and several of the other members engaged in inside activities.

The Auxiliary held an afternoon meeting and ate their evening meal at the Green Hill's Country Club. They joined the Medical Society meeting for the scientific program. The principal speaker, Robin Anderson, M.D., from the Cleveland Clinic, spoke on "Plastic Surgery".

At the business meeting held prior to the evening meal, T. R. Hayes was elected councilor to fill out the unexpired term of Dr. F. E. Keeling who had resigned, being re-activated by the military. Dr. Gordon Wilder of Anderson was elected alternate councilor. Dr. Arvin Henderson was elected president and Dr. Paul Sparks was elected secretary-treasurer of the Eighth District Medical Society.

T. R. HAYES, M.D., *Councilor*.

NINTH COUNCILOR DISTRICT

During the past year two meetings were held in Lafayette prior to the Council meetings. Representatives of several of the societies in the district were present. Matters to come before the Council were discussed but, unfortunately, representatives from some of the societies were not in attendance. Those attending the meetings expressed the opinion

that they were worthwhile and if sufficient interest is manifested, similar meetings will be held during the coming year.

The Annual Ninth District Medical Society Meeting took place in Noblesville on May 27, 1953. The meeting was well attended. The annual golf tournament took place in the morning. There was an excellent scientific meeting in the afternoon. The speakers were Dr. Harris B. Shumacker, Jr., of Indianapolis, Dr. William Browning of Indianapolis and Dr. Walter G. Reich of Chicago. This meeting was well attended and the speakers provoked a great deal of discussion from the floor.

The meeting of the Delegates followed the scientific meeting. Dr. Paul D. Crimm, President of the Indiana State Medical Association, and Mr. James A. Waggener, Executive Secretary of the Indiana State Medical Association, were present at the Delegates' meeting. Dr. Crimm emphasized the scope of the activities of the Indiana State Medical Association and the large number of committees necessary to carry on the work of the Association. Mr. Waggener spoke of the importance and value of the County Health Councils and offered the services of the Headquarters Office to counties wishing to set up a County Health Council.

A banquet at Forest Park completed the program. Mr. C. Walter McCarty of the Indianapolis News addressed the gathering. The meeting was adjourned to convene in Lebanon in 1954.

WEMPLE DODDS, M.D., *Councilor*.

TENTH COUNCILOR DISTRICT

No report.

ELEVENTH COUNCILOR DISTRICT

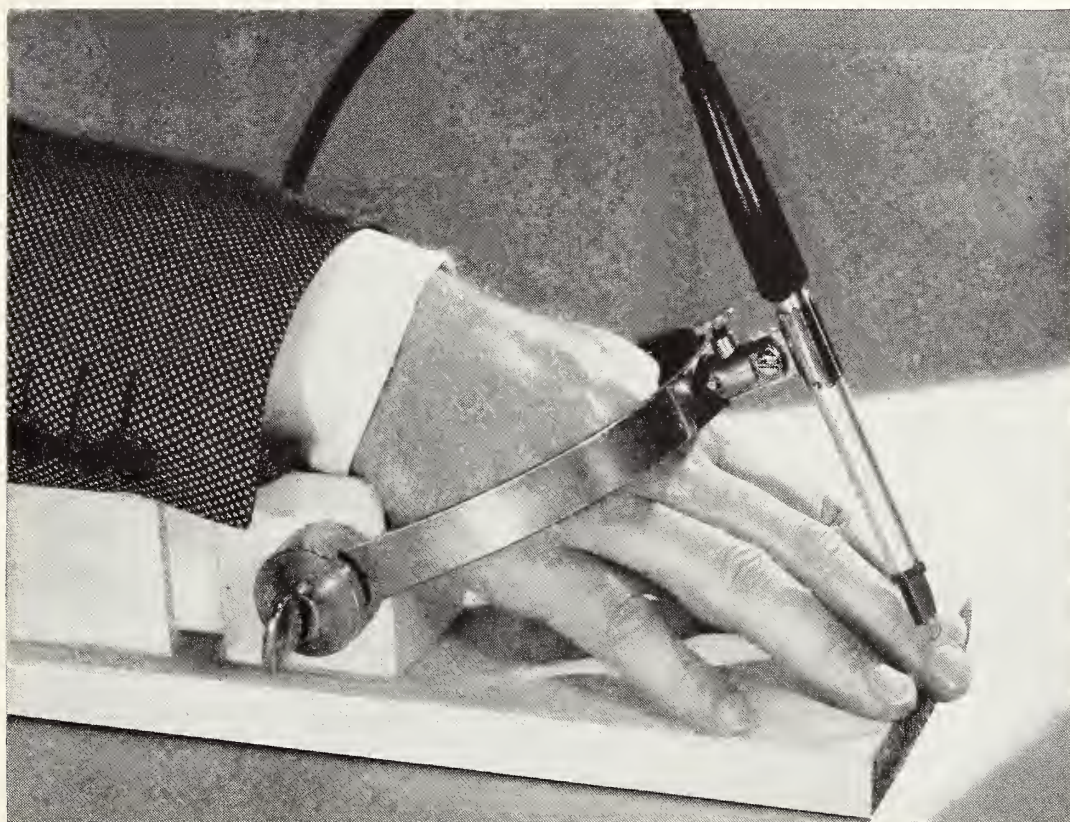
Two successful district meetings were held during the year. The fall meeting was held at Logansport State Hospital, September 17, 1952, where Supt. John A. Larson proved himself a very able host. The afternoon program consisted in a psycho-surgical clinic and a symposium on neuro-surgery with presentation of cases and a paper on "Thrombosis and its Treatment" by Chris Segard, M.D. The evening program was a talk on "The Doctor's Income Tax" by Mr. Floyd Kerlin of Indianapolis.

The spring meeting was on May 20, 1953 at Delphi. The afternoon program included a talk by Dr. R. J. Meyer of the Armour Laboratories on ACTH and Cortisone and a symposium on "Public Relations". On the panel were Dr. A. C. Yoder of Goshen, former National Physician of the Year, Dr. Chas. C. Crampton of Delphi, a former Indiana Physician of the Year, Dr. Reuben A.

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Solomon, internist of Indianapolis, and Dr. William M. Browning, pediatrician, also of Indianapolis.

Officers elected at this meeting were: President—Dr. George W. Wagoner, Delphi; Secretary-Treasurer—Dr. W. H. Hutto, Kokomo.

We are trying to go ahead with the pre-Council meetings with the officers of the component county societies, although sometimes the attendance is not what it should be. Meetings of this kind have been held at Logansport, Peru and Wabash the past year. Such meetings were devised for the purpose of letting the Councilor inform the county society officers of some of the contemplated changes in procedure or policy of the Indiana State Medical Association, and conversely to listen to the expression of the said societies as to what they want changed or done. The policy of the Indiana State Medical Association has always been along the most democratic lines, and this should be continued in every way possible.

Detailed reports of the various counties follow:

Carroll County—Active members, 9; senior, 1.

New member—Robert M. Seese, M.D., Delphi, formerly of Cleveland, Ohio.

Removed—Thomas C. Brown, M.D., to Houston, Texas, where he has accepted a residency in radiology in Hermann Hospital.

Activities: Red Cross Blood Bank; school examinations.

Cass County—Active members, 32; senior, 5.

Dr. Charles Landis of Logansport and Dr. John T. Ferguson formerly of Hamlet, will serve as resident physicians in psychiatry at the Logansport State Hospital. Dr. Leonard Lund, returning from army service, has been added to the staff of the hospital, while Dr. Gordon T. Brown, formerly on the staff, has now joined the Norways Foundation Hospital resident staff, at Indianapolis.

Grant County—Active members, 49; senior 2.

The following Marion surgeons received Fellowships in the American College of Surgeons last September—Drs. Richard M. Davis, H. Allison Miller and James P. Lowell.

Dr. Merrill S. Davis was elected to the Board of the James Whitcomb Riley Association at its recent annual meeting.

Dr. H. Allison Miller has been named President of the Board of Marion General Hospital.

We pause to salute Dr. and Mrs. George R. Daniels, who were signally honored by being selected Indiana's guests of honor at the First Western Hemisphere Conference of the World Medical Association at Richmond, Va., April 23-25. George's comment,—“Yes, they treated us mighty fine down there.”

Howard County—Active members, 41; senior 3.

New members—Stanley M. Mendelson, M.D.,

formerly of Indianapolis, a graduate of Indiana University School of Medicine in 1952, and Philip Eldon Prather, M.D., also from Indianapolis and a 1952 graduate of Indiana University School of Medicine. Dr. Mendelson has had U.S. Navy experience, and Dr. Prather was in the U.S. Army. Both men are in general practice in Kokomo.

Huntington County—Active members, 22; senior, 3.

Miami County—Active members, 17; senior 4.

Dr. A. L. Kuntz, formerly of South Bend, has been appointed resident physician at the Peru Railway Hospital, succeeding Dr. Harold E. Van Dyke.

We were all happy at the recovery of Dr. and Mrs. C. R. Herd from a serious automobile accident last fall, which confined them to the hospital for several months. Dr. Herd is now back in practice, although he felt that he should not continue in his post of Secretary-Treasurer of the District, which he has filled so ably the past several years.

Wabash County—Active members, 22; senior, 4.

Dr. Walter V. Matteuci, formerly an instructor in medicine at the University of Pennsylvania, has joined Drs. W. D. Dannacher and J. T. Stoops in a new clinical group at Wabash.

Dr. Arthur P. Rhamy has accepted a position as chief resident in urology at Philadelphia General Hospital after completing post-graduate work at the University of Pennsylvania. The appointment is for two years starting July 1, 1953.

Although mention is made elsewhere of the passing of the following doctors of the Eleventh Councilor District, I should like to pause a moment in silent respect for:

Dr. Will W. Holmes of Logansport, who served this district society twice as its president,

Dr. Lindley H. Eshleman of Marion,

Dr. E. F. Kratzer of Kokomo, who practised for many years at Waupecong in Miami County,

Dr. John F. Powell of Greentown, a senior member,

Dr. Verne E. Baldwin of Amboy, not a member,

Dr. Russell P. Schuler of Kokomo, formerly very active in county and district societies.

ELTON R. CLARKE, M.D., *Councilor*.

TWELFTH COUNCILOR DISTRICT

A report by Jack L. Eisaman, M.D., of Bluffton was published following the May 21, 1953 meeting of the 12th District.

Since that time M. B. Catlett, M.D., has resigned as Councilor of the 12th District of the Indiana State Medical Association.

At a meeting held on July 30, 1953 at the Elks Country Club, Maurice E. Glock, M.D., of Fort

Wayne, was elected Councilor to fill the unexpired term of Doctor Catlett.

A golf tournament and dinner was sponsored by Charles Pfizer and Company of Terre Haute for that meeting.

M. B. CATLETT, M.D., *Councilor.*

THIRTEENTH COUNCILOR DISTRICT

The component medical societies of our district have been active during the past year. Emergency medical service is being provided for our citizenry. Precouncilor meetings with the officers and delegates of the county societies of the district have been held. The attendance has been somewhat disappointing. The attendance has been better, however, when the meetings have been held before the House of Delegates meetings when there is more of an agenda to discuss.

We still have a shortage of hospital beds in the district but several hospital additions and new hospitals will be completed this coming year.

Regular monthly meetings with the union and insurance committee of Studebaker and the Welfare Department are continuing to be successful in South Bend. Public relations have been much improved by these meetings.

The annual meeting of the 13th District Medical Society was held in Elkhart on November 19, 1952. In the morning a seminar on neoplasm of the lung was given by four doctors of Elkhart and South Bend. The luncheon meeting was addressed by our State President, Dr. Paul D. Crimm, who gave a fine talk. The business meeting was held in the early afternoon and the following officers were elected: President, John E. Luzadder, M.D.; Vice-President, Otis R. Bowen, M.D.; Secretary-Treasurer, O. E. Wilson, M.D.; Alternate Councilor, G. O. Larson, M.D.

A scientific program in the afternoon was addressed by James L. Wilson, M.D. of the University of Michigan who talked on, "The Complications of Differential Diagnosis of the Types of Bulbar Poliomyelitis". The second paper was given by Stanley Gibson, M.D. of Northwestern University on "Rheumatic Fever in Children". The third paper was given by Ben W. Lichtenstein, M.D. of the University of Illinois. His topic was "Headaches—Differential Diagnosis and Treatment". After the dinner the doctors and their wives were addressed by W. W. Bauer, M.D. of the American Medical Association whose subject was "Health Education".

At the same time that the district meeting was going on the women's auxiliary of the 13th district had a meeting which was fairly well attended.

The next annual meeting of the society will be held on November 18, 1953.

KENNETH L. OLSON, M.D., *Councilor.*

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Reports of Committees

THE EXECUTIVE COMMITTEE

During the year, now closing your executive committee has met regularly each month to transact the business of the Association. The year has been a busy one, and many of the meetings have required long hours of deliberation on matters of importance to the profession and the affairs of the Association.

Matters that could wait and those of important policy nature were referred to the Council for their deliberation and decision.

Our last report mentioned the fact that some operational changes would be placed in effect at our Headquarters office. Perhaps the most important improvement has been the new membership receipt form which was placed in use at the beginning of the year. During the summer a poll of all county secretaries was taken in which their opinion was sought regarding the continued use of the form and suggestions they might have for improvement. Every county replying stated they felt this a great improvement, that it had saved them time, and requested that the same system be adopted as a permanent method for collection of dues.

The bookkeeping system has been simplified and streamlined in accordance with our accountants' recommendations.

The committee cooperated with the Committee on Public Policy and Legislation in calling a meeting of representatives of all allied professions for the purpose of discussing what could be done in regard to the proposed bill to consolidate all licensing under one board.

It has been necessary, due to the widespread demand from industry and others for the Executive Committee to order additional printing of the Publicity Committee's pamphlet "Getting Well at Home." It might be noted here that nearly a quarter million of these have been distributed. The largest single request came from Inland Steel which requested 22,500 copies for distribution to their Indiana employees.

The committee has undertaken a study of the Malpractice Insurance rates, and is hopeful that before the end of the coming year, something definite may be accomplished. At this time it ap-

pears that one of the reasons for the higher rates is the fact that Indiana physicians have not concentrated their policies with any one company, thereby not permitting a favorable experience rating. We have at this time elicited an agreement from the St. Paul Mercury Indemnity Company, which is the approved carrier of Malpractice Insurance for the members of our Association, an agreement to write policies on Indiana physicians at a rate of 16% per cent below the Bureau published rate.

In February of this year your Association received a request from the AMA asking that good representation from Indiana be sent to the meeting of the National Health Council in New York. As a result Dr. J. William Wright and the executive secretary were sent.

It was the announced intention of this conference to begin a campaign to initiate a movement to support the Report of the President's Commission on Health Needs of the Nation. However, so successful was the response to the request of the AMA, physicians were in the majority in attendance and this effort was thwarted. As a result of the direction taken by the National Health Council, many of the major contributors, including the AMA have announced withdrawal of their financial support.

Membership Report

Listed here is a detailed report of membership in the Association. You will note the first column of figures indicates the total membership of each county society as of December 31, 1952. The second column gives the membership as of September 1, 1952 and the third column lists the membership as of September 1, 1953, which furnishes you with a comparison of our membership as of September 1. The fourth column indicates the number of physicians in each county who are delinquent with their 1953 dues. It should be understood that this latter figure not only includes those who have not paid their dues, but also includes those physicians who are members of the respective societies and who are eligible for Senior membership, those excused from paying dues because of being in military service and for whom the State Office has not received a receipt from the county society so stating.

MEMBERSHIP REPORT
Indiana State Medical Association

County Society	Members 12-31-52	Members 9-1-52	Members 9-1-53	Number Delinquent	A.M.A. Non-Members
Adams	18	17	13	1	1
Allen	210	205	212	2	3
Bartholomew-Brown	29	27	35	0	1
Benton	10	10	10	0	3
Boone	20	20	19	0	0
Carroll	10	9	9	0	0
Cass	36	35	38	0	0
Clark	24	22	30	0	2
Clay	12	12	11	0	0
Clinton	24	23	22	1	2
Daviess-Martin	26	26	25	0	1
Dearborn-Ohio	15	15	15	0	0
Decatur	12	11	11	0	0
DeKalb	20	20	21	1	1
Delaware-Blackford	100	100	95	6	11
Dubois	16	13	18	0	2
Elkhart	89	89	88	0	4
Fayette-Franklin	22	22	17	0	1
Floyd	30	26	32	1	1
Fountain-Warren	17	17	16	0	0
Fulton	12	12	12	0	1
Gibson	25	25	24	0	0
Grant	49	48	49	2	0
Greene	22	21	20	0	13
Hamilton	23	23	21	0	11
Hancock	18	13	14	4	6
Harrison-Crawford	13	12	11	0	1
Hendricks	17	15	14	2	1
Henry	41	40	41	1	3
Howard	44	44	42	0	2
Huntington	23	23	22	0	1
Jackson	18	18	18	0	7
Jasper-Newton	17	16	15	2	0
Jay	16	16	14	1	4
Jefferson-Switzerland	27	27	26	0	1
Jennings	8	8	9	0	3
Johnson	21	19	21	0	0
Knox	46	46	42	2	5
Kosciusko	14	14	13	0	1
LaGrange	8	8	9	0	0
Lake	316	299	304	13	60
LaPorte	78	73	78	1	3
Lawrence	24	24	24	0	4
Madison	95	90	91	2	6
Marion	893	883	931	11	30
Marshall	17	16	21	1	1
Miami	19	19	19	1	3
Montgomery	26	24	26	0	0
Morgan	16	16	17	0	1
Noble	23	23	24	0	2
Orange	13	13	12	1	
Owen-Monroe	55	53	56	0	10
Parke-Vermillion	24	22	23	0	4
Perry	10	10	10	0	0
Pike	8	8	8	0	
Porter	24	24	28	0	2
Posey	11	11	9	2	1
Pulaski	8	7	6	0	3
Putnam	19	19	18	0	0
Randolph	21	21	20	0	4
Ripley	12	12	11	1	4
Rush	13	13	13	0	1
St. Joseph	206	204	203	0	5
Scott	4	4	4	0	
Shelby	22	22	22	0	0
Spencer	6	6	7	0	3
Starke	7	6	7	0	1

County Society	Members 12-31-52	Members 9-1-52	Members 9-1-53	Number Delinquent	A.M.A. Non-Members
Steuben	11	11	13	0	3
Sullivan	16	16	17	0	3
Tippecanoe	98	96	95	1	2
Tipton	11	11	11	0	0
Vanderburgh	191	191	186	1	16
Vigo	112	111	117	0	0
Wabash	23	23	25	0	4
Warrick	8	8	8	0	0
Washington	6	6	7	0	0
Wayne-Union	69	69	67	3	14
Wells	28	28	27	0	0
White	4	3	8	0	0
Whitley	11	11	10	0	0
	3,760	3,673	3,759**	64	283

** Includes 143 in military service

109—\$10.00 members (residents and interns)

249—senior members

75—members, dues remitted by Council

Medical Defense Activities

1. **Malpractice cases.** A year ago, at the time of this report, August 1, 1952, the following thirteen cases were pending before the committee, none of which was closed during the year, leaving 13 cases still pending:

Case No. 200—Filed February 12, 1932. Pending.

Case No. 251—Filed September 25, 1942. Pending.

Case No. 255—Filed September, 1945. Awaiting assignment for trial.

Case No. 268—Filed September 7, 1948. Pending.

Case No. 269—Filed September 28, 1949. Pending.

Case No. 270—Filed September 28, 1949. Pending.

Case No. 271—Filed September 16, 1949. Pending on change of venue.

Case No. 273—Suit not yet filed. Effort being made to obtain settlement.

Case No. 274—Suit filed May 25, 1951. Pending.

Case No. 276—Filed April 11, 1951. Pending.

Case No. 279—Filed May 19, 1952. Pending.

Case No. 280—Filed March 11, 1948. Trial court directed verdict for defendant; plaintiff took an appeal to Appellate Court; petition for transfer to Supreme Court now in preparation. Expense to date, \$365.00, paid August 8, 1952.

Case No. 281—Filed May 20, 1952. Pending.

Since August 1, 1952, and up to August 1, 1953, the following four new cases have come before the committee, none of which has been closed, making a total of seventeen cases pending at the present

time as against thirteen unclosed cases at the same time last year:

Case No. 282—Suit filed August, 1952. Pending.

Case No. 283—Suit filed August 28, 1952. Pending.

Case No. 284—Suit filed June, 1951. Pending.

Case No. 285—Suit filed, October, 1952. Pending.

2. Medical Defense Fund Statement, from August 1, 1952, to August 1, 1953:			
Balance, August 1, 1952.....		\$ 5,093.31	
Receipts:			
Dues,			
3—1951 Members	\$ 3.75		
153—1952 members	191.25		
3,371—1953 members	4,213.75	4,408.75	
Interest on bonds		517.60	
		<hr/>	
		\$10,019.66	
Disbursements:			
Malpractice fees	365.00		
Salary, Association attorney...	1,890.00	2,255.00	
		<hr/>	
Balance in Medical Defense Fund checking account, August 1, 1953.....		\$ 7,764.66	

THE JOURNAL

Several changes have been made in THE JOURNAL, including a new cover, and new make-up and format. These changes have been instituted in the hope they will improve the appearance and readability of THE JOURNAL. An editorial secretary and an assistant to schedule advertising and keep records have handled the full office routine of THE JOURNAL.

During the past year, four special issues of THE JOURNAL have been published. In October the Annual Convention Issue, in April a Cancer issue, July the annual Yearbook and August the General Practice issue.

Advertising

Survey of advertising for the first six months of 1953 shows a slight decrease over the preceding six months. This is explained by the fact that changes in the staff of THE JOURNAL were taking place at this period, adjustments in advertising rates were being made, and there has been a general falling off of advertising volume in state medical journals, according to the report of the State Journal Advertising Bureau of the AMA.

Efforts are in progress at the present time to increase the advertising volume of THE JOURNAL and it is hopeful the efforts will prove successful.

Figures on advertising for the first six month period of each of the last three years and for the first six month period of this year are as follows:

From The State Journal Bureau of the AMA	1950	1951	1952	1953
Sold direct by Journal	\$ 7,836.86	\$ 9,070.88	\$ 8,134.65	\$ 7,935.62
	4,467.31	3,813.82	5,027.65	4,766.60
Total ..	\$12,304.17	\$12,884.70	\$13,162.30	\$12,702.22

Printing Costs

Cost of printing THE JOURNAL during 1952 and the first six months of 1953 shows an increase over the last two years. This is caused by two factors, more pages and more illustrations plus increasing printing costs. Costs are in relation to the number of pages.

Year	Cost	Number of Pages (Inserts Excluded)
1948	\$26,391.00	1,380
1949	\$28,572.41	1,360
1950	\$24,664.07	1,324
1951	\$23,735.75	1,304
1952	\$26,563.85	1,424
1953 (6 months)	\$11,847.90	620

The following table shows the number of JOURNAL pages for the past six years and indicates percentages of reading and advertising material in relation to the totals.

Year	Read- ing	% Read- ing	Adv. Pages	% Adv. Pages	Total Pages	Avg. Pgs. per issue
1947	681	45	837	55	1518	126.5
1948	703	49	707	51	1410	117.5
1949	740	53	652	47	1564	130
1950	690	51	664	49	1354	112.8
1951	674	51	660	49	1334	111.1
1952	845	58	605	42	1450	120.8

WALTER L. PORTEUS, M.D., *Chairman*
JAMES W. DENNY, M.D.
PAUL D. CRIMM, M.D.
W. H. HOWARD, M.D.
ROY V. MYERS, M.D.
ELTON R. CLARKE, M.D.

BOARD OF APPEALS ON PATIENT-PHYSICIAN RELATIONS

The Board of Appeals on Patient-Physician Relations respectfully submits to the House of Delegates the following report of its official transactions for the year 1953.

The Board has held five official meetings since the 1952 session of the Association and will meet once more before the House of Delegates convenes in October, 1953.

Four complaints carried over from the 1952 docket as "incomplete" have now been closed. Ten new complaints have been received and considered to date by the Board. Eight of these cases have now been officially closed. Two 1953 cases are pending before the Board, awaiting further evidence or final action by the Board. None of the cases on the 1953 docket required or was referred to the Council for disciplinary action.

No substantiated evidence of malpractice, extortion or exploitation of patient, neglect of duty or other unethical conduct of a physician was presented to the Board.

Most of the complaints were amicably settled by the physician and complainant soon after the Board's notification of complaint. Some were referred to the physician's county medical society for

adjustment. In all cases the Board has respected the prerogatives of the physician and the county medical society.

The Board has been able to refute unjustifiable charges against the physician in some cases and believes it has aided in making better patients out of some very troublesome ones.

The Board has received no objection or remonstrance on the official disposition of any case and has received several gratifying letters from complainants and physicians.

It is the opinion of the Board that sound, ethical, scientific and humanitarian practice of medicine predominates in Indiana.

It believes that the establishment of this Board and its rules and methods of procedure are adequate to detect and cite for disciplinary action those few physicians who exploit the public and bring criticism upon our profession.

The Board finds that complaints of the neurotic, the psychopathic and those indoctrinated with the panacea of socialistic compulsory and regimented medical care are its greatest problem. These cases often require more time for consideration and investigation than the justifiable complaints. These charges, usually absurd, vicious or malicious, must be answered or they run rampant in the public square. They injure the reputation of good doctors and are a greater menace to American medi-

cine than the few charlatans within our ranks. Just how to combat this problem will require time, study and experience.

We, therefore recommend that the Board of Appeals on Patient-Physician Relations be continued as an integral part of the Indiana State Medical Association.

A. P. HAUSS, M.D., *Chairman*
MINOR MILLER, M.D.
CLIFFORD M. JONES, M.D.
C. S. BLACK, M.D.
WILLIAM C. REED, M.D.
HARRY P. ROSS, M.D.
R. R. CALVERT, M.D.
C. H. McCASKEY, M.D.
R. W. WILKINS, M.D.

COMMITTEE ON COUNTY MEDICAL SOCIETY OFFICERS' CONFERENCE

Your committee is proud of the program presented during the Annual Conference which was held at the Claypool Hotel in Indianapolis on Sunday, January 11, 1953. Our greatest difficulty each year is our attempt to outguess Mother Nature and her weather. It appears that the weatherman views the date we have set for the meeting, and then selects the same date for the season's worst weather.

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In spite of the weather on January 11, we are happy to report a good attendance, although not every county was represented. We believe the program was outstanding, and we list herewith the program for the 1953 meeting:

Welcome and orientation by President Paul D. Crimm; a discussion of legislation before the State Legislature by Drs. Harold Ochsner and J. William Wright, co-chairmen of the Legislative Committee; a review of the services of the Association by Jas. A. Waggener, executive secretary; a discussion of press relations by Mr. Arthur P. Tiernan, executive secretary of the Vanderburgh County Medical Society; "What They're Doing in Other States," a review of other state association programs by Mr. Larry Rember of the AMA Public Relations staff.

The luncheon speaker highlighted the program, when Mr. William L. McGrath, president of the Williamson Heater Company of Cincinnati, and Employer Delegate to the International Labor Organization, outlined the necessity for vigilance to prevent socialization of our nation through International Treaties formulated by the ILO.

We were also honored by the attendance of Mr. Hiram Jones, director of the American Medical Association Medical Education Foundation, who reported on the national campaign, and paid tribute to the physicians of Indiana for their support of the fund. At this time Mr. Jones presented three of the first certificates awarded by the Medical Education Foundation to Doctors J. O. Ritchey, James W. Denny and H. H. Inlow for their gifts of one thousand dollars each to the Fund.

R. R. PLOUGHE, M.D., *Chairman*
L. G. MONTGOMERY, M.D.
R. W. LAVENGOOD, M.D.
H. S. RAMSEY, M.D.
CLAUDE D. HOLMES, SR., M.D.
FRANCIS P. JONES, M.D.
J. P. GILLIATT, M.D.
FRED D. HOUSTON, M.D.

COMMITTEE ON CONSTITUTION AND BY-LAWS

At the time this report was required for publication there had been no meeting of the committee inasmuch as no matters had been referred to us for consideration.

There are several matters that should require the attention of the committee, and it may be that these will be brought before the House in the form of a supplemental report.

WILLIAM H. GARNER, M.D., *Chairman*
PAUL R. TINDALL, M.D.
A. G. BLAZEY, M.D.
WALTER K. ROBINSON, M.D.
DONALD G. MASON, M.D.
I. C. BARCLAY, M.D.
LOUIS C. BIXLER, M.D.
GEORGE S. ROW, M.D.

COMMITTEE ON INDUSTRIAL HEALTH

The Committee on Industrial Health this year embarked on a project of trying to formulate a definition for pneumoconiosis and particularly for silicosis. This is to be a working definition which will be of great benefit to the profession and will help the Industrial Board in their desire to be fair and equitable in adjudicating the various lung involvement cases. Without something concrete to refer to, their position has been very difficult and somewhat arbitrary. Furthermore, great difference of opinion is found in the testimony of doctors, although each is perfectly sincere in his opinion. Due to the fact that there has been no agreement as to a satisfactory definition it was thought that some definite information on this subject would be of value to all concerned. A special committee was appointed to work on this subject. They have had several meetings and have come up with a definition which they believe is a

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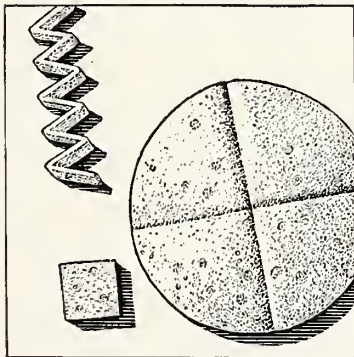
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workable one. However, before it is presented to the State Association for publication and endorsement, they expect to give it further consideration to be sure that it is in excellent shape. The chairman of this committee is Dr. Allan Harcourt. Working with him, are Dr. Russell Henry, Dr. Donald Brodie, Dr. Harold C. Ochsner, Dr. Louis W. Spolyar, Dr. Jas. H. Stygall, and Dr. Chester A. Stayton. You will note that the group is made up of chest and x-ray specialists as well as an industrial hygienist. We are very happy and proud of the fine work which they have done up to date. When the objective is accomplished, we shall present it to the State Association through channels.

We find that our County and District Industrial Medical meetings are better attended than any medical meetings in any part of the state. Every doctor appreciates that he is an industrial doctor to some extent.

Your chairman and some members of your committee have represented the State Association at meetings of the American Medical Association, Industrial Medical Association meeting in Chicago; two meetings of the Central States Society of Industrial Physicians and Surgeons; Industrial Medical Association Meeting in Los Angeles and the Territory of Hawaii Medical Society meeting in Honolulu. We had very interesting talks by various speakers who presented valuable information and suggestions. One suggestion which we have thought for a long time that our State Association should try, was recommended by several associations, which is to devote a certain amount of time at each State convention to Industrial Medicine. At the Hawaii meeting, one day was devoted entirely to Industrial Medicine. We find that several of the other states are doing that and they have found it goes over very well. Your committee feels that your State Association should allocate to the Industrial Health Committee at least one-half day's program for Industrial Medicine. We would prefer a full day, but we would be happy with one-half day. We advocate this because there are very few doctors in the State of Indiana who do not do some form of Industrial Medical work, and also due to the fact that 95% of the Industrial Medical work that is done, is done by the general practitioner, rather than a full-time doctor in industry. We feel that it should be the duty of the State Association to provide leadership in this area and thus disseminate useful information of this character to the members who are doing industrial medical work.

At the AMA Industrial Conference in Chicago, which was attended by the Industrial Health Chairmen of the State Associations, it was recommended that industrial medicine be taught to undergraduates in our medical schools, again due to the fact that so many will go out as general practitioners and will do some industrial medicine. It was further suggested that some central place be established where one could write for informa-

tion on toxicology or any industrial medical problem; Industrial Medical Meetings to be held in plants; and, that medical schools hold two-day postgraduate courses on industrial medicine, as is being done at Harvard University. These ideas have all been carried out at different times by the Indiana State Medical Association, which is, of course, very gratifying to us.

The Industrial Medical Association, as you know, is starting an accreditation program for the Medical Department of Industry. This seems to be a very valuable and admirable plan, which is approved by the AMA and the American College of Surgeons, as well as other medical organizations. We hope to dignify medicine in industry, and bring it to its rightful position.

"Medical Directives for the Nurse in Industry" have been sent all over the country, and have been adopted as a model in many states. Also, we get calls very frequently for the Code of Ethics which a great many of the states have adopted.

I want to take this opportunity to thank the members of this committee for their excellent help and very fine work. We have not had a lot of meetings this year, owing to the fact that we had embarked on this one particular project. We have been attending the other meetings to see if there was something of value that we could bring back to the State of Indiana.

E. S. JONES, M.D., *Chairman*

C. POWELL VAN METER, M.D.

E. B. LAMB, M.D.

J. H. CLEVINGER, M.D.

C. L. LUCKETT, M.D.

RICHARD C. SWAN, M.D.

B. E. FITZGERALD, M.D.

GARVEY B. BOWERS, M.D.

H. W. HELMEN, M.D.

EDGAR H. WEBER, M.D.

L. W. SPOLYAR, M.D.

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

The Committee on Medical Education and Hospitals during the past year has continued its efforts in the three areas in which it has been active for the past two or three years, mainly telephone postgraduate seminar programs, recording of lectures for loan library, and the Medical Education Foundation. We shall report on each of these three sections of our activity as follows:

TELEPHONE SEMINAR

For the third successive year the committee has conducted these telephone seminars and during the past year eight programs have been sent by telephone wire to many of the Indiana societies. It has been an interesting observation on the part

of the committee the large number of the societies which have changed over from the telephone seminar to receiving copies of these programs by recording. The number of societies listening to the program has decreased during the past year, but there has been a large increase in the societies which desire the program by method of recording; therefore the programs are still going to about the same number of societies as in past years. Recorded programs are perhaps more useful to some of the societies as it permits a little more flexibility in programming at the society level, and does not necessitate the physicians being gathered in a central place at a certain hour and certain night of the month. Therefore the committee has expanded its activities in the field of recordings and has experienced a wider demand for these during this past year.

We are happy to report again that this activity of your committee has been self-sustaining and it has not been necessary for us to ask the association whether to carry on with this work.

RECORDING LOAN LIBRARY

Last year we reported to you that we had been successful in obtaining permission from the American Medical Association to record many of the scientific lectures given during its national session in Chicago. These have been good on tape and lists have been sent to the physicians of the state of Indiana. In addition during the past year we have recorded lectures by outstanding authorities who spoke before the Indiana Academy of General Practice and other medical groups within the state. These lists have also been issued so that our members might have knowledge as to what is available through our loan library.

The response of the profession to avail themselves of these recordings has not been up to the expectations of the committee. In the very beginning there was a large demand, but this has tapered off for some reason.

It has been interesting to note that in the past few months more requests for rental of these recordings has been received from physicians throughout the United States than have been received from Indiana physicians. The committee has received several requests from physicians desiring to rent these recordings, and a rental system has been established for physicians residing outside the state of Indiana. Also it is being used by some physicians who are convalescing from illness and have the desire to keep up on medical literature.

We feel that the newness of this service of our association to our members is perhaps the explanation of the reason of the poor utilization that has been made up to this time by our members; however we consider this is an important phase of the association's activity and wish to continue

our efforts in this field. We believe that as time goes on and as physicians become more accustomed to the availability of these recordings that the library system of our association will necessarily be greatly expanded and will be utilized more fully by our membership. Reports of those who have used this service are most encouraging and it is felt that as this work becomes better known more and more physicians will utilize the library as a means of continuing their education and to reduce their amount of reading time.

MEDICAL EDUCATION FOUNDATION

The activity of the committee toward the Medical Education Foundation has required more of the committee's consideration than the other programs during the past year. We are happy to report that since the beginning of the campaign and as of the 11th of August, 1953 we have collected and forwarded to the National Education Foundation Fund the sum of \$84,916.59.

In the report of the National Medical Education Foundation for the year 1952 it was interesting to note that in the period beginning January 1 and ending December 31, 1952 Indiana was the largest contributor of all states to this fund. The report shows that 1,217 Indiana physicians contributed a total of \$58,152.54 during the year. The next state in line was New York showing the total amount of money from that state as being \$53,023.47 representing gifts from 995 physicians. The committee feels that the Indiana State Medical Association can be proud of this effort on the part of the members of our association and feels that the House of Delegates should express its sincere appreciation to those members of our association who have made contributions to this fund since its inception.

Your committee will continue its efforts and has asked each county medical society to cooperate by soliciting its individual members for this fund. While reports are not complete the returns are encouraging, for it looks as though the committee will eventually reach the goal it set two years ago.

On the other side of the picture 1952 report shows Indiana University has received as benefits from this fund a total of \$62,390.

As you will remember this committee sought permission of this House of Delegates to establish the Indiana State Medical Education Foundation Trust. This request was approved and the trust fund was set up with a board of trustees composed of six representatives named by the association and six named by the Indiana University board of trustees as the governing body of this trust. Early in 1952 a check was received from the Foundation in the amount of \$37,462.97. This check was turned over to the board of trustees of

the Indiana Medical Education Foundation and deposited in the trust fund. In July of this year another check in the amount of \$47,000 was received and this too has been turned over to the Foundation Board of Trustees. The committee feels that the efforts on the part of the members of the association in the cooperation of this fund has been most worthwhile. While the amount received by the medical schools may seem small, nevertheless it is to be remembered that this represents a very healthy return on the \$2,000,000 endowment if such were available for our present school. It is the intention of the committee to continue its efforts and to cooperate in every way it possibly can with the National Foundation which is trying to make our campaign a continuing success. As pointed out in the beginning this is not a one time effort but must be a continuing effort on the part of the physicians and others if we are to take up the slack to make it possible for our medical schools to operate during this period of loss of income from established endowments and other income.

The committee has been informed by the National Fund that during November of this year a greatly expanded effort will be made on the part of the National Fund to urge physicians to contribute generously to the effort. A tax mailing will be sent out in November, in which it calls attention to the fact that many times gifts to the Foundation which are deductible from tax income reports, will not cost the individual physician much in the way of actual cash, as the deduction might save him enough in his taxes to make his gift to the medical school cost him just a few dollars. We feel that the Indiana State Medical Association and the individual members thereof should make a continual effort and do everything possible to support the Medical Education Foundation. We believe it to be an obligation of the physicians to devote their full cooperation to this effort to prove that the medical schools may be saved from federal subsidy and regulations through the voluntary effort of the medical profession. It is the hope of your committee that Indiana physicians will accept their responsibility in this cause and will give generously, thus proving they are willing to do their full share in this fight to save our medical schools from government control.

JAMES W. DENNY, M.D., *Chairman*,
D. W. PARIS, M.D.
EDWIN A. LAWRENCE, M.D.
HARRY E. KLEPINGER, M.D.
JOHN A. SHIVELY, M.D.
ALFRED ELLISON, M.D.
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COMMITTEE ON PUBLIC POLICY AND LEGISLATION

The past committee year has been one of intensive work on the part of every member of the committee. The 1953 Session of the Indiana State Legislature, is one long to be remembered by the profession and many of the events which took place during the session may be considered as advance indications of events to happen in the 1955 session.

In all the years of the Indiana State Medical Association, it is doubtful if ever, as many bills which had a bearing upon the practice of medicine were introduced in a single session as was the case in 1953. Some 49 such bills were introduced and while some of them were only of nuisance value, many would have had far reaching effects.

As was expected the chiropractors were back during the session with their usual attempt to procure special legislation in favor of their group. In a stronger position than ever before, having a member of their group in the House, and with a highly organized lobby activity they were successful in getting their bill through the House. Fortunately our friends in the Senate refused to take action on the bill, and the chiropractors' hopes died in the closing hours of the Senate.

The bill was amended by the Committee in such a manner as was thought would discourage the chiropractic block, but instead of being discouraged, they urged passage of the bill. This indicates that they are changing their tactics and hope to be successful in getting special chiropractic legislation of any type on the books with the feeling that once this is accomplished, they will achieve success in future years in coming before the legislature and chipping away at the objectionable provisions of previously enacted laws until they are successful in getting them removed one by one and they have a law which will permit them to legalize their practice without the public protective features now included in the Medical Practice Act.

The committee has been hampered by an attitude of apathy in regard to this issue on the part of a seemingly large segment of the profession. If the efforts of your committee are to have any chance of success, it will require the concerted effort of every physician to do his utmost in an effective educational campaign to debunk many of the statements being issued by the chiropractors. Their publicity leads some to believe that chiropractors are an oppressed minority group and that

the medical profession, by denying them licensure, is keeping the public from "having free choice of physician." The fact is that the chiropractors are eligible for licensure under the present licensure law, and they have a chiropractor member on the medical registration board. But for some reason or other they refuse to raise their standards to those prescribed by law, so they may be qualified for examination and licensure.

This issue will again be before us in the 1955 session. In fact, hardly a week goes by at the present time when one cannot find an item in the public press, regarding a meeting of the chiropractic group and their lay organization and telling of plans being made for getting their bill through the 1955 session. The medical profession too, should be just as concerned as to what we are to do to meet this continual effort on the part of the chiropractors.

As most of you know, many other bills were introduced which were important. The purpose of one was complete reorganization of the registration boards; it would have placed all state registration boards under one head. This would have eliminated all direct control of the licensing boards by the various professions concerned. This bill failed to get through the Senate.

Another bill was introduced which would have had the effect of doing away with the Indiana State Board of Health as we have known it placing the Board under a new Department of Health. This bill was rewritten by the Senate, with the Board of Health being left as it was, but incorporated under the name of the new department. The bill did destroy the Mental Health Council and established an entirely new department of mental health. There are indications that another effort may be made in the 1955 session to have the original bill passed. This issue should concern every physician.

Labor introduced a bill to provide "free choice of physician" under the present Workman's Compensation Act. Both pro and con sides in this

issue claimed that the medical profession was in accord with their thinking on this issue. As a result your committee called both labor and management together for a conference in which our neutral position in this issue was made clear. While this bill failed to get through we have been informed that an entirely new Workman's Compensation Act will be introduced by labor in the 1955 session.

Each year more and more legislation with a bearing upon the medical profession is introduced at both the State and National levels. At the national level, your committee has cooperated fully with the American Medical Association which is in constant contact with National legislative matters. Telegrams and letters have been forwarded in accordance with the request of the AMA Legislative Committee.

We believe we are correct in our observation of the greatly increased amount of medical legislation, appearing in every state and Congress. *We would recommend that every physician take an interest in the issues as they arise, and prepare himself to discuss them with his patients on an intelligent and understanding basis.* For we must clarify the issues in the minds of the public, and ourselves as well.

This is one of the prices of freedom in the practice of the healing arts. Such freedom will prevail only if we put forth a maximum effort to defend and uphold the high principles of medical practice as we have known it.

HAROLD C. OCHSNER, M.D. } Co-
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COMMITTEE ON PUBLIC RELATIONS

The activities of the Public Relations Committee during the past year have been devoted to carrying on the duties assigned us by this House. We have published the "Newsflash" each month and have endeavored through this media to keep the membership fully informed on current happenings. We believe "Newsflash" is serving a worthwhile purpose and from comments received by the committee indications are that this newsletter has a wide reading audience among our members.

We sincerely hope that from time to time, the members of the Association will keep us apprised of the content of the "Newsflash" and will furnish us with bits of information which they would like distributed to their colleagues. Information in the "Newsflash" is confidential in nature and therefore offers a source for the distribution of information that might otherwise not permit its being carried in THE JOURNAL.

Our committee has cooperated throughout the year with the activities of other committees when there was a public relations question involved.

The committee has been active during the year in preparing a public relations guide for the individual members and component county societies. This guide is now completed and its publication and distribution is essential if the efforts of your committee are to be of service to the profession. We feel that to make a public relations program effective and understood, this guide should be published and a copy supplied to each member for his personal file. We would therefore request during the coming year, a sufficient additional appropriation to permit this being done.

This marks the first attempt of the Association in its 104 years to prepare and publish a public relations program and guide book and it should serve a very worthwhile purpose if we are to improve our public relations.

PUBLIC RELATIONS MANUAL

The Public Relations Committee of the Indiana State Medical Association believes:

1. The Indiana State Medical Association and its component county medical societies must continue an active public relations program.
2. We must not fall into the error of accepting that illusory cliché "Good deeds speak for themselves" but to make the enlightened activity of medical organization an integral part of the public's concept of medicine, we must achieve sound public relations.
3. That Machiavelli's statement of four hundred years ago applies to public relations today—"Physicians say that at the beginning, the disease is easy to cure and hard to diagnose, but if it is not diagnosed and treated at the beginning . . . it grows easy to diagnose and hard to cure." We would be neglectful of our

duty to our profession if we did not continue treatment to effect a cure now that our somewhat late diagnosis has been made.

4. The public relations activity of the State Medical Association and its component societies will succeed if we continue to—
 1. Keep our definite objectives always in mind.
 2. Take a long time view in the developing of public confidence in medical organization.
 3. Support a staff familiar with the technique and mediums for putting policies into action.
 4. Closely align the public relations activities of the component county societies with that of the state association.
 5. Always work in the interest of helping the public to better understand the program of the medical profession.

A BETTER UNDERSTANDING OF YOU AND YOUR PROFESSION

Public Relations Suggestions
Prepared Especially for the
County Medical Society and
the Individual Physician

PRESS, RADIO AND TELEVISION RELATIONS

Perhaps no two groups of professional people are more misunderstood by each other than the physician, the newspaper publisher or editor, the radio station manager and the television station owner. Yet, nowhere will you find two professional groups that have more in common, or who need each other more in their daily lives than these two.

Relations with the communications group are very important, and in fact necessary if the medical profession is to have these molders of public opinion on its side. These relations are not easy, for remember the newspaper reporter or publisher, the radio and television station owner are, in their opinion, just as professional in their field as you consider yourself in yours. If this can be fully understood in the beginning by the physician, and treated in this light relations can be easy and a long lasting friendship will develop which on various occasions will be worth more to the physician and the county society than the

sum total of the gross financial worth of all the physicians in the county put together. Of course, the reverse can be true, and many times is true, that poor relations do more damage to the practice of medicine than all the collective financial worth of the physicians in the community. All your money could not right the damage these communications professions can do, yet this does not mean that physicians and medical societies must bow to the every whim and wish of these men—it means that there is a need for friendship and understanding between all.

In dealing with the communications industry we would call the following to your attention. We believe it will be helpful to you in developing good relations in this field.

PHYSICIANS AND THE PRESS

Physicians and representatives of the press may differ:

The physician *searches* cautiously for the exact truth.

The press representative is *interested* in the exact truth.

The physician is technical: "a compound comminuted fracture of the tibia and fibula."

The press representative prefers simple words: "a broken leg."

Physicians and the representatives of the press are alike, too!

Neither likes to be inferior to anyone.

Both will fight against odds: one to help his patient; one to supply news to the public.

Both prefer facts to rumor.

Both like help on difficult and unpleasant cases (as well as the easy ones).

In working with representatives of the press also keep in mind:

Do not ask for favors.

Do not resent articles, if you were uncooperative.

Do not deny minor errors, if you failed to explain.

Do not forget to say "thank you."

Be as courteous with them as you expect them to be with you.

Be as truthful with them as you expect them to be in handling a story in which you or your society might be involved.

Usually they will respect your confidence, if you request it and have valid reason for doing so.

Relations, good working relations, with the communications profession of your community are most important as they will befriend you if they know and have a mutual trust with you. They will help you and your society in many of your endeavors to bring about better public relations. They can omit why you "did not arrive before the patient dies", or they can say you "were playing golf and would not come."

Therefore your Public Relations Committee urges every physician and every county medical society to conscientiously strive to better relations with these citizens of your community and recommends the following:

1. Invite your newspaper, radio and TV people to some of your affairs. Welcome them and make them feel at home, get to know them better, and let them get to know you better.
2. If you are planning some important civic event or health proposal for your community, let them in on your secret, seek their opinion on its merits. If they criticize your ideas, don't "get mad and fly off the handle". If their objections can't sell you that you are wrong, sell them that you are right. Friendly discussion will always solve the problem, and you will both remain friends.
3. Appoint an official spokesman for your society and permit his name to be used in any release given out by your society.
4. Tell your newspapers when your society meeting will be held, and who will talk and on what subject. This, to them, is news in the community—it's good public relations for you, too! It lets your fellow citizens know you are going to be busy with a meeting, that you are devoting some of your free time in an effort to learn more about the scientific development of medicine so that you will be a better physician.
5. Always remember the newspaper, the radio, and the television can be just as critical as you, and they can tell more people about it faster than you can. Also they can shout praise, and tell more people about it faster than you, and can even give medical men credit that you, as a physician, can not do without the risk of sounding boastful.
6. Good relations with the communications profession should be a must with every physician and every county society.
7. Develop a local "Code of Ethics" so you may know what the communications profession expects of you, and they will know what to expect of you.

AVAILABILITY AS A PHYSICIAN

The Physician's Responsibility

As a physician, your responsibilities to the public of your community are many, and often appear burdensome. As a guardian of the health and lives of your patients, you are expected to be available always in time of need. Many times demands are unreasonable—but to your patients they are always within reason. Remember, the patient has no medical education. Time spent in educating pa-

tients in how to use their doctor is profitable to both.

Your patients are human, and if you take the time to talk to them as friend to friend, they too will learn that you are human, with the same problems as they, and with the same desire for eating regularly, obtaining a reasonable amount of rest, and with a longing to have some time with their families. Your patients will understand this and go along with these desires of yours, yet you must always be ready to help them in a real emergency, and always make sure they know who to call if you are away on an extended leave.

As physicians, holding the trust we do, we have the same obligation, to use a comparison, as a public utility. Our standing as doctors of medicine depends on how we care for our patients.

Therefore, your Public Relations Committee strongly urges the following as a must for every physician and every county medical society:

1. Explain fully to your patients your policy of medical practice. That you, as their family physician, intend to be available to them but there are times when this will not be possible and tell them the reasons.

2. Explain that, if you are available, you are willing to care for them in any real emergency.

3. If you are to be absent from the community for an extended period tell them who to call if they need medical attention.

4. Encourage and actively participate in a county medical society emergency call system. Take your share of the responsibility in making the plan work. Every licensed physician is a doctor of medicine, regardless of his specialty of practice. Be a true physician, be willing to cooperate and do your share. In many instances the fact that a specialist is making a house call in a time of need is an excellent gesture to the people of the community.

5. Let the public know that the medical society has an emergency call service for their use when they cannot locate their physician in an emergency.

6. Advertising this service regularly in your local newspaper, by your society, is not considered unethical, but rather as good public relations for medicine.

7. Encourage people to get acquainted with a doctor in the community and make arrangements with him to be available for their medical needs.

PHYSICIAN PARTICIPATION IN COMMUNITY LIVING

Physicians may be criticized by their fellow citizens for their lack of interest in community affairs. In many cases, the people are right in the feeling that the physicians of their community are only

interested in themselves or mildly interested in community life.

Remember, as a physician, the community owes you no more than you, as a citizen, owe to the community. Living and practicing in a community, you are just as much of a citizen as the butcher, the baker, and the candlestick maker, who also live and practice their trade in the community. Yet, frequently, physicians, for one reason or another, shun their civic responsibilities and thus create poor public relations for themselves and for the medical profession as a whole.

Yes, of course, you contribute to the Boy Scout and Girl Scout drives, and maybe help with a few dollars toward the decorations of the public square at Christmas time, but this is not enough.

To be a citizen, to live in your community, means that you too, must be willing to give of your talents in planning and helping solve the problems of your community. It means that you should take an active interest in your community government, be willing to serve in an official capacity if the public wishes, and, at least be willing to participate in the discussions with your fellow citizens of your community affairs.

Remember, you get out of your life in the community only what you put into it—so be a good citizen—be an American—participate in the affairs of the citizens, not only with dollars, but with elbow grease and gray matter as well.

Your Public Relations Committee recommends, therefore, that every physician citizen and every county medical society do the following:

1. Actively participate in the affairs of your community as citizens and not just as physicians.

2. Join your local Chamber of Commerce, or business men's organizations, participate in their meetings the same as the man in the corner grocery.

3. Attend meetings of your community government, take part in the discussions, hold office if that is the wish of your fellow citizens.

4. Don't consider a monetary contribution alone, as the discharge of your obligation.

5. Take an interest in your Public Schools; here is a very valuable place for physicians to be of service. The P.T.A. is looking to organized medicine to lead in health affairs. If organized medicine doesn't do this, someone else will. In rural communities, there is much of mutual interest to the medical society and the farm groups. The mutual understanding of the problems and a willingness to discuss common interests is valuable to both. Health is important to both groups, and the doctors are expected to take their normal place and leadership.

Recently, in many communities of the United States, labor and medicine have been getting together for discussions of mutual problems. In many

instances, common good has been brought about to some degree by these discussions. We can no longer exclude ourselves from such discussions. It would be well for every medical society group to know the labor leaders of their communities and to be willing to work with them. Remember that the people of this group are citizens also.

6. Get to know your local newspaper editor, or publisher, your radio or TV station owner. Get their ideas on subjects and problems that confront your community; you'll be surprised how they will, in turn, ask you for your ideas.

7. Work with youth groups in your community.

8. Speak before lay groups. Society members should be available to speak before lay groups on health subjects. This gives an excellent stage for telling medicine's story to the people.

YOUR PROFESSIONAL RELATIONS

Relations, right in your office with your patients, are the beginning of good or bad public relations for the entire profession. No money, regardless of amount, no effort on the part of your parent organizations is enough to build good public relations for the profession. In fact, money and effort spent in this direction has been entirely wasted if one or a few physicians fail to hold themselves to good public relations principles in their daily practice.

Here are a few suggestions that develop good or bad public relations:

Your Receptionist

Usually your receptionist or office nurse is the first person to greet your patients upon their arrival at your office. Discourtesy, rudeness or inattention start the patient off on the "wrong foot" before you ever see him. As a result, your patient is in a bad frame of mind, feeling sorry for himself, mad at you, and maybe critical of the entire medical profession. Kindness and understanding, with attention on the part of your receptionist to your patients, will go a long way toward starting your patient off thinking you are a good doctor, and the profession, as a whole, is raised in his opinion. We would advise, if you have not already done so, that you make it a point to have your office help read the pamphlet prepared by the AMA, entitled "Winning Ways With Patients". Copies are free and may be obtained by writing the Public Relations Department, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

Courteous Telephone Service

The telephone as an emissary of good will and good public relations cannot be overlooked. A good telephone voice on the part of your office receptionist, your family, and even you, as the physician, is most important. Too often, in answering the telephone, one's voice and manner unintentionally

denotes discourtesy. Therefore, there are several rules which should be handled with care when using the telephone.

A patient phoning the physician, in most cases, is surrounded with fear because little Johnny is sick and running a fever. Many times symptoms described over the telephone you readily diagnose as nothing serious and a condition that can wait until the following morning. But the anxious parent does not understand this. When talking to your patient over the phone, while you may be busy, behind on your schedule, or sleepy, nevertheless be reassuring and interested. Don't brush off the call lightly. Be more considerate than if you were seeing the patient in your office.

One of the major complaints against the physician comes from poor telephone manners on the part of the employees of the physician. Discourtesy more often than not develops into community criticism and the patient is angry. Therefore, it should be the requirement of every physician of his employees and his family that common courtesy and understanding always be employed in handling telephone messages.

When a patient or a neighbor of the patient calls your home, in the first place, they want to talk to the physician. If you are not present, rather than say: "I don't know where he is," it is just as easy to employ a few kind words: "Mrs. Jones, I'm sorry the doctor is not in, but I will attempt to locate him and see that he gets your message, and I am sure he will contact you just as soon as possible." Have the person answering the phone get the facts and call you even if you are in the midst of a social evening. You know your patient, and with some facts regarding the symptoms, you will be in position to evaluate the urgency of the case.

As you well know, in a large percentage of these cases, a few reassuring words over the phone will satisfy the patient and renew their confidence in you and relieve their fears. If, for some reason, you cannot make the call, why not phone them and explain that you are tied up and can't leave your present patient, but you will send Dr. so-and-so if this will be satisfactory. You can express your sincere regret that you are unable to come right away, but if you can get there an hour later tell them so, and plan to arrive at the time stated. Or take the time to make another call, telling them you will be later than you thought, inquire about the condition of the patient, and if your judgment warrants, suggest that another physician be called or sent by you, or arrangements made for the patient to be taken to the hospital, and you will see him there.

The telephone can be one of your best friends if properly used; likewise, it can cause trouble. When talking face to face with a person the words spoken often have a different meaning than the same words spoken over the telephone. Therefore, telephone relations are more difficult than personal

public relations. Carelessly answered questions and carelessly worded conversations over the telephone with improper tone of voice leads to more misunderstandings of intent and purpose than any other one factor.

Your Public Relations Committee Recommends:

1. That each physician keep a close check on the telephone manners of his employees and his family.
2. That office employees be carefully schooled in telephone habits. (Your local telephone company can be helpful by giving you free literature and films.)
3. That you, as a physician, make it clear to your office staff and your family that you want to be informed promptly and fully on every telephone call regarding one of your patients.
4. That you always let either your office staff or your family know where you may be located.
5. That you establish the habit of calling your patient and inquiring about their call to you.
6. That you make it a habit to call your patient informing him that you are being delayed and will reach his home at a later time and specify the approximate time. Call again if you are unable to make it.
7. Don't treat telephone calls lightly, be even more considerate over the phone than you would be if talking to the patient in your office.
8. Participate in and let your patients know about your emergency telephone service operating in your community. Even a reminder of this service included with your statement for your services would be a worthwhile investment.

HUMAN RELATIONS

Waiting Room Time

Nothing is more disconcerting to your patient, or to you, than to be kept waiting for long periods of time. Nothing is more damaging to good human relations than to keep your patients sitting in your waiting room for hours without explanation before you see them.

If you work on an appointment basis, see your patient at the appointed time. If your office girl is scheduling your patients too close together, slow her down and have her schedule your patients at different intervals so you can keep your appointments. Of course, unexpected emergencies will throw your schedules into a tailspin, but if they do be sure your receptionist tells the patient that you have been called on an emergency and there will be some delay, asking, "Do you wish to wait, or would you prefer to schedule another appointment?" Nine times out of ten the patient will wait

until you return, and feel sorry for you in doing so instead of becoming irritated because you are making him wait. After all, a scheduled appointment is a contract, so to speak. Your patients may be foregoing another appointment to keep the one with you. They have scheduled their time to permit their appointment, the same as you. They are anxious to keep the appointment, and more often than not, they are on time, while the physician is usually late. In this case, it's only common courtesy to make apologies.

A patient may have requested time off from his employment to keep his appointment with you and his boss is expecting his return at a certain time. If you delay his return to his job—he will hear from his boss—result, another unhappy patient.

We recommend, therefore, that you always, without fail, have your receptionist keep your patients informed about your schedule. If you are running late, if you are called out, or if you are running ahead, keep your patients informed. They will think much more of you and your office practices.

Night Calls

One of the most damaging causes of poor relations with the public for the entire profession is the failure of physicians to make night calls, or to be helpful to a patient when they do not make night calls.

Let us be honest with ourselves. When we decided to enter the practice of medicine, we knew there was no schedule calling for people to become ill between 9 A.M. and 4 P.M. We knew then that people become ill at all hours of the day and night, and that we, as physicians, would be called upon to minister to their ills.

Therefore, we have an obligation to take care of the public regardless of when they become ill, and not at our pleasure.

Admittedly, there are calls which are unwarranted. Admittedly, there are calls which should have been received during regular office hours—but these, by and large, are not the patient's fault as much as they are our fault for our failure to properly educate our patients on the use of modern day medical service. Even if we do educate them, we still have an obligation to take care of the sick regardless of when they call for us.

If you are one who makes night calls, then you are doing your share to uphold the principles of the practice of medicine.

If you are one of those who refuse to make night calls—you still have an obligation as a physician. Don't say, "I'm sorry, I don't make night calls, you'll have to get someone else." Be helpful, recommend one of your colleagues who does and give them the telephone number. If nothing else, explain courteously that you do not make night calls and suggest they call the physicians' exchange, giving them the number.

In no case, unless you are mad at yourself and the entire profession, clip your caller off with, "I

don't make night calls," and in a tone of voice that says, "You so-and-so, don't bother me again."

Explanation of Illness

Explain is one word that means so much in modern day public relations. In talking to your patient about his illness, or the illness of someone in his family, forget those "twenty-five dollar words" you learned in medical school and talk to your patient in language he can understand. Don't say a "fractured right femur"—say a fractured thigh bone. Fancy medical terms had their place years ago, but not today. Use common every day language that your patients know and understand. You'll be surprised how much more your patients will think of you as a physician. In many instances, understanding his illness makes it possible for the patient to cooperate with the physician.

Discuss Your Fees

An honest, ethical practicing physician has nothing to be ashamed of in discussing his fees. In making a recent check of all complaints received by medical societies, those regarding the misunderstanding of fees headed the list for reasons for complaints.

Chances are you personally don't buy any product or service without asking what it will cost. Your patient is human too; he needs your care and your professional skill, and many are hesitant about discussing fees inasmuch as the idea has been developed through the years that this is one thing you just don't do.

As a physician, it is your responsibility to discuss your fees. Of course, in many cases, it is impossible to nail the cost down to the exact penny, but you can give them some idea of the cost. This will give your patient an opportunity to discuss his financial situation with you and will furnish you with some idea as to the ability to pay. If your fee will be hard on the patient's supply of ready cash, plans can be made for him to pay on an installment basis, and this gives both him and you some basis for understanding each other.

Remember your own attitude when someone touches your pocketbook a little too heavy. Apply some consideration to patients.

It may seem distasteful to you to discuss your charges; it may hurt your vanity to even feel that this is necessary. But it is better to lose a patient before you render the service than to lose him through a misunderstanding over your fees. If the latter is the case he will tell everyone he meets that you are a so-and-so, by saying, "I wouldn't go to that guy, he charged me too much." A little talk about this fee before the service would have prevented stories such as this circulating throughout the community about you—and about the profession as a whole.

So, let's make it a must. Let's discuss and explain our charges to our patients before the

service is performed. There are times when it is unwise or impractical to discuss fees with patients. The doctor would appear too economically minded if he discussed fees at times of great emergency. This can be done at a diplomatic time, and many cases will test the ability of the physician to select the right time. In general, however, it is wise for the patient to know what his charges will be.

Those Monthly Statements

Physicians are noted for their reputation as the world's worst business men—and chances are that much of this opinion is brought about by the poor common business practices employed by many physicians.

Improper billing is another cause of complaint. Why not itemize your bill? Sure, it takes more time, but it cuts down complaints and dissatisfaction. Imagine yourself getting a bill from the garage on the corner, "for services rendered—\$85.00." You'd hit the ceiling, and refuse to pay the bill without an explanation. Your patients feel this way about your bill too.

How do you feel when the plumber fails or refuses to send you a bill promptly at the end of the month for his work, but suddenly several months or even a year later you receive a bill for work you had forgotten about? Then you begin to wonder if you haven't already paid the guy, and proceed to tell yourself what you think of any guy that would wait so long to send you a bill. Your patients feel this way about you, too, when you don't bill them promptly.

So, why not instruct your office girl right now that, hereafter, she is to invoice your patients regularly at the end of each month—and in itemized form, too. You'll be surprised how much easier your accounts are collected.

It is a proven fact that the longer a bill goes the harder it is to collect.

If two or more physicians are involved in the same case each should render his own bill. This removes all ideas about "fee-splitting" and "ghost-surgery."

In the matter of charging and billing for your services, "Honesty and Fairness are Virtues." The total fee should be rendered without any thought of insurance participation. If your patient is fortunate enough to have this insurance, it should be applied to your regular fee. The fact that your patient is not paying the part of the bill paid by the insurance carrier should not be a factor in determining the bill.

Consideration for Organized Medicine

The activity of every physician, good or bad, reflects to the public relations of the society as a whole. At the present time, physicians are becoming more interested in politics and in government. It certainly behooves all of us to let our society know if we have personal political ambitions. We

want our physicians to participate in governmental activities, but we do feel that his activities should be considered by the society also. We can expect more consideration to be granted to our society, as a whole, from people in government than would be granted to one individual doctor. In addition to this, the prestige of our society goes up the more our elected officers are utilized in consultation to state and national governments.

SUMMARY

This guide barely touches upon some of the essentials of good public relations. It should always be remembered that a physician occupies a place in the esteem of his fellow men, and we would want it no other way. This position has been brought about by the exemplary conduct of our predecessors and colleagues who practiced these tenets so that we might enjoy freedom in our practice. This constantly should be in the thoughts of every physician in living his life and in his daily activities.

It is unfair for a physician to lose sight of his ethics in his practice—thereby bringing disrespect upon his colleagues who are attempting to do a conscientious job in the practice of medicine. It is also unfair for a component medical organization to permit the unethical practice by any one of its members. A society which permits this is as guilty as the physician himself, and this gives bona fide reason for the public to question the high ethics of our profession. When a society condones such practice by one of its members, the other members who are working themselves overtime to uphold the ethics and principles of the practice of medicine, are permitting one of their group to destroy the good effects of their efforts faster than they are able to win the public to the side of medicine.

Before any physician criticizes a colleague for any practice, he should be in full possession of all facts involved and should enter into a discussion of the situation with the colleague before making any statement. Even then, criticism should not be given to a colleague's activity until the local society has had a chance to correct the situation. The human equation exists in all physicians, the same as all men. A carelessly made remark is responsible for 90% of the malpractice cases—and your high malpractice insurance rates.

Remember, good public relations will be established when every physician ethically does his work with consideration for his patients in the nighttime as well as in the daytime.

Earl W. Mericle, M.D., Chairman
F. B. Mitman, M.D.
O. O. Alexander, M.D.
Davis W. Ellis, M.D.
Charles P. Schneider, M.D.
Jerome A. Graf, M.D.

COMMITTEE ON PUBLICITY

Your committee has met regularly in the headquarters office during the last year for the purpose of handling all newspaper releases, radio and television programs.

The usual "Hints on Health" column releases for use in some 150 newspapers in Indiana have been continued, as have the 15 minute radio programs over Indianapolis station WFBM, also several news releases have been prepared for release to Indiana newspapers throughout the year.

"HINTS ON HEALTH"

The work of the committee on preparing the "Hints on Health" column is a routine matter but is considered important. We feel it necessary that the public receive accurate and proper information on medical subjects. With this thought in mind the following articles have been released through the "Hints on Health" column:

It's In Your Head	Flu—Pneumonia
Hip Fractures	Old Age
Careless Parents—	Coma
Injured Children	Fit For Survival
Convulsions	Rheumatic Fever
Water and Health	Palsy
Alcohol Neuritis	Ingrown Toenails
The Winter Killer	Heartburn
The Common Cold	Sensitivity
Bed Wetting	Your Physician
Children	Growing Old
Glaucoma	They Had It Too
Overweight	Stuttering
Germ Warfare	Be Normal—Be Healthy
Diabetic Gangrene	Neuralgia or Neuritis
Animal Diseases	Don't Show Off
Medical	Heat Exhaustion
Advancement	Chiggers
Psychiatry	70 Years Young
Blood Tells	Trichinosis
Your Baby	Rehabilitation
Poison Ivy	Mothers' Feet
Constipation	Seven Ages of Man
200,000 Saved	

GENERAL NEWS RELEASES

The following general news releases were sent to all newspapers in the state during the year:

A series of Newspaper releases submitted by the committee on chronic illnesses.

A release on behalf of the Board of Appeals explaining the activities of this particular board.

General Convention Story

Story on Speakers

Hunters Caution on Tularemia

Holiday Hints for Health

A release on Polio

ISMA exhibit at the Indiana State Fair—A general release on Polio.

RADIO PROGRAMS

Radio Station WFBM has continued to carry the weekly transcribed series procured from the AMA Bureau of Health Education. The subjects of these radio programs were timely, one running each week throughout the year. It is the belief of the committee that the Indiana State Medical Association should express to the owners of radio station WFBM the appreciation of this Association for this fine co-operation during the last year.

QUESTION AND ANSWERS SERIES,

Indiana Farmers Guide

At the request of the Indiana Farmers Guide the "Hints on Health" columns were also sent to this farm publication for the last year and they requested that we cooperate with them by answering questions on health which the readers might submit. As a result of this, many letters were answered by the committee throughout the year that were received from the readers of the Farmers Guide seeking further information on matters of health. It was interesting to note that many of these inquiries came from surrounding states bordering Indiana.

MISCELLANEOUS

The committee has cooperated with other committees of the association assisting in every way possible to make the educational campaign and public relations program effective. The Committee has at all times been willing to work with the other committees with any programs which they might have.

E. H. CLAUSER, M.D., *Chairman*

D. S. MEGENHARDT, M.D.

NORBERT M. WELCH, M.D.

A. F. GREGG, M.D.

J. O. RITCHEY, M.D.

R. M. McDONALD, M.D.

HOMER G. HAMER, M.D.

COMMITTEE ON RURAL HEALTH

The Rural Health Committee set up its program for the year to continue the work which had been started in previous years, and with the thought in mind to try to conclude some of these projects that had been in committee planning for the past year or two.

I

PROCUREMENT OF PHYSICIANS FOR RURAL AREAS

A. THE BROCHURE

Under the direction of L. E. How, M.D., the brochure for physicians seeking locations to practice was completed, and they are now available to any physician requesting them. These contain county maps of areas requesting physicians, economic and civic data on these communities, and professional information pertinent to the community. Through the co-operation of the Indiana Society of Architects with the Rural Health Committee, plans have been made available for a rural doctor's office. These plans are somewhat flexible as to size, including possible additions as the need may occur to the doctor. Approximate costs of the various types of construction are included with the plans. So far as is known, this is the only service of this type which is available without cost to the physician. This was run off as a contest, and the various plans which were submitted by the architects were judged on July 30, 1953 in Indianapolis by Dr. Frank B. Ramsey, editor of THE JOURNAL of the Indiana State Medical Association and a committee of the architects. Also included in the brochure is a pamphlet put out by the American Medical Association entitled "Rural Practice Can be Fun" by John R. Roger, M.D. of Bellaire, Michigan. A map of Indiana which shows the doctor-population ratio and location and sizes of hospitals is also in this brochure.

B. THE COMMUNITY BULLETIN

For the communities which are seeking physicians, a Community Bulletin has been started by the State Office. This is to be mailed out from the Headquarters Office each month to communities which have requested physicians. It contains the names and addresses of doctors who are seeking locations. The first of these went out in the month of August.

C. LECTURES FOR CLASSES AT INDIANA UNIVERSITY MEDICAL SCHOOL

These lectures were again given by J. E. Duding, M.D., of Hope, to the senior medical students. The first was given on November 29, 1952, and the second on January 31, 1953. They followed the

same pattern as in the past year. During the first half of the lecture period, Doctor Dudding told the students of the advantages of rural practice. The last half was thrown open for the students to ask questions. This part of the program showed a lively interest on the part of the students, and many questions were asked which Doctor Dudding answered from his fifteen years experience as a general practitioner in a small rural community.

II

REGIONAL CONFERENCES

Five Regional Conferences were held under the planning of Robert W. Kuhn, M.D. These were at Lafayette, Washington, New Albany, Plymouth, and New Castle. Other committees and officers of the Indiana State Medical Association helped with these programs, and took part in them as in the previous year. Some of the topics discussed at these meetings covered the following subjects: procurement of physicians for rural areas, problems of the profession with Welfare Departments and Township Trustees, formation of Health Councils, ways of simplifying rural practice, political aspects of medicine, civil defense, medical education methods at universities, and the preceptorship program.

III

HEALTH WORKSHOPS

Four Health Workshops were held during the year at Columbia City, Shelbyville, Terre Haute and Rochester. These were organized under the direction of the committee by the Woman's Auxiliary to the Indiana State Medical Association through Mrs. Jack Eisaman, their Rural Health Committee chairman. The programs were conducted on a varied number of subjects in regard to health problems generally. Physicians were used on each panel, in addition to personnel from the voluntary health agencies. An effort was made in presenting these programs to the laity, to give them good, clear, and understandable information concerning Cancer, Mental Health, Child Health, Heart Diseases, Nutrition, Tuberculosis, etc.

IV

HEALTH CONFERENCES AT PURDUE

The Rural Health Committee was invited to participate in the Winter Agricultural Conference at Purdue, January 8, 1953. J. E. Dudding, M.D. was a member of the panel discussing "Organizing for Health and Safety".

At the Summer Conference, July 29, 1953, the Rural Health Committee co-sponsored "Health Day". Several members of the committee served on panels as "Session Consultants". In the panel

on Heart Disease Harris V. Shumacker, M.D., of Indianapolis spoke on "New Trends in Heart Disease Control", and John W. Ferree, M.D. of the Division of Public Health Education, American Heart Association, New York, spoke on "Community Aspects of Heart Disease Control" and showed the film "Round Trip". Hart E. Van Riper, M.D. of New York City spoke on "Our Chances and Polio" in the panel entitled "Facts About Polio". Charles J. Cameron, M.D., Medical and Scientific Director of the American Cancer Society, New York City, spoke on the "Progress of Cancer Control" and illustrated his lecture with slides. At the end of the cancer panel he also showed a film dealing with self-examination for breast cancer. These men all gave outstanding lectures, and great interest was evinced by the large number of people in the audiences, totaling some 3,000, in spite of the terrific heat.

On Wednesday evening at the Hall of Music, just prior to the performance of the Home Demonstration Club Chorus, a short program was given in honor of Dr. "Davy" Crockett, and Mrs. Charles W. Sewell. Just about eight years ago, Mrs. Sewell, who was then the Administrative Director of the Associated Women of the American Farm Bureau Federation, became alarmed over the post-war shortage of physicians in certain rural areas of the country, and called on her friend, Dr. Crockett, to see what could be done. This meeting was the beginning of a line of thought which developed into the present Rural Health Organization between the physicians and the farm organizations interested in bettering health conditions. Paul D. Crimm, M.D., president of the Indiana State Medical Association, introduced George F. Lull, M.D., general manager of the American Medical Association, who presented Mrs. Sewell and Doctor Crockett with plaques designating their great service to their fellowmen in the field of health. Doctor Crockett and Mrs. Sewell expressed their thanks for the unexpected honor with appropriate remarks.

V

INDIANA FOUNDATION FOR COMMUNITY HEALTH

ELI GOODMAN, M.D., Charlestown
JOHN BRETZ, M.D.

April 29, 1953 a temporary organizational meeting was held with the five allied organizations, namely: Indiana State Dental Association, State Hospital Association, Indiana State Nurses Association, Indiana Veterinary Medical Association, and the Indiana Pharmaceutical Association, for the purpose of forming a Foundation for Community Health organized at the state level. The Rural Health Committee was ably assisted by Paul D. Crimm, M.D., president of the Indiana

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State Medical Association, James Waggener, executive secretary of the Indiana State Medical Association, and Albert Stump, attorney for the Indiana State Medical Association. Mr. Stump drew up the basic constitution and by-laws for the Foundation. On June 18, 1953 the Foundation was made a permanent organization. The following officers were elected: Mr. Henry Heine of the Indiana Pharmaceutical Association, president, Miss Helen Weber, R.N. of the State Nurses Association, vice-president, Mr. James Waggener of the Indiana State Medical Association, secretary-treasurer. The board of directors is made up of two members from each of the six organizations.

Dental Association—Drexel Boyd, D.D.S., Charles Howell, D.D.S.

Hospital Association—Edmund J. Shea, Jack A. L. Hahn.

Nurses Association—Miss Helen Weber, R.N., Miss E. Nancy Scramlin, R.N.

Medical Association—John M. Bretz, M.D., Eli Goodman, M.D.

Pharmaceutical Association—Henry W. Heine, A. T. Ehrhardt.

Veterinarians Association—W. W. Gaverick, D.V.M., J. E. Jordan, D.V.M.

This is a parent organization to encourage the organization of like foundations at a county level for the formation and guidance of county health councils, and like organizations.

NATIONAL RURAL HEALTH CONFERENCE

The eighth National Rural Health Conference was held February 26, 27, and 28, 1953 in Roanoke, Va. J. E. Dudding, M.D., was designated by the Association as its representative.

The first day's meetings were held by the Council on Rural Health of the American Medical Association, under the guidance of F. S. Crockett, M.D., Lafayette, Indiana, chairman of the Council. These meetings were directed particularly to the State Committees on Rural Health, and to other state committees handling rural health problems. The theme of this day was "Doctor Participation in Community Programs." The group was extended greetings by Walter B. Martin, M.D., Norfolk, Virginia, member of the Board of Trustees of the American Medical Association. Dr. Crockett spoke on the theme of the day and urged all the doctors to join lay groups in their community. He stated that voluntary health groups should be considered as working bodies—not as executive bodies. Franklin D. Yoder, M.D., Director of the State Health Department of Cheyenne, Wyoming spoke on "The Place of Public Health Service in the County Health Councils." He stressed the duties of the local health department, warning that they should

not neglect minor illness education. He also stressed preventive medicine.

Mack Shanowitz, M.D., Commissioner of the State Health Department of Richmond, Virginia spoke on "The Place of Public Health Service in Community Health Counselling." He urged the formation of Health Councils and explained that although their duties are similar to those of the State Board, that the councils help initiate programs of self help in the communities. He also spoke on the fluorination and chlorination of water supplies, Pasteurization and Grade "A" milk. Charles R. Henry, M.D., member of the Rural Health Committee of the Arkansas Medical Society of Little Rock, Arkansas, spoke on "The Place of the Physician in Rural Health Activities." He stated that the physicians should be willing to be out front in these organizations, and should accept leadership willingly. He also felt that it was up to the doctors to take steps to relieve the doctor shortage. He urged that the young doctor be freed from the limitations that shackle him on what he should and should not do, stating that in most cases these young doctors are better able than the older doctors to take care of whatever problems come to them in their practice. The last talk of the day was given by Haddon A. Peck, M.D., Chairman of the Rural Health Committee of the Kansas Medical Society of St. Francis, Kansas. He spoke on the problems of getting the young doctors to the rural areas.

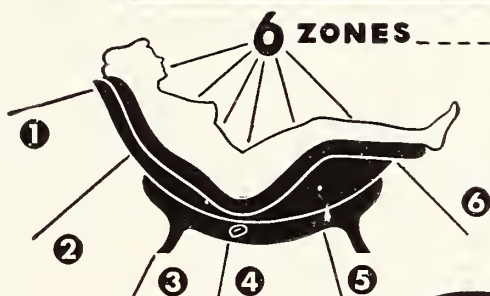
The meetings of the next two days included the above personnel as well as representatives from various farm organizations. The theme of these meetings was "Widening the Highway to Health". The keynote speech was given by F. S. Crockett, M.D., and was entitled "Looking Back to Look Ahead." He reviewed the activities of the past eight years, since the Council on Rural Health was first instigated as a Committee on Rural Health in the American Medical Society in response to an invitation by the American Farm Bureau which was becoming alarmed by the loss of physicians in rural areas. Aid and assistance has been given to the American Medical Association by advisory members from the American Farm Bureau Federation, The National Grange, the National Milk Producers Federation, the Farmer's Union and the Farm Foundation. Later, the Committee on Organization and Policy of the Land Grant Colleges and the American Agriculture Editor's Association joined and gave support. Forty-three of the State Medical Associations now have Rural Health Committees which give us support and stimulate interest among state farm groups for the mutual help in rural and community health problems. The objective of these groups has been the benefit of the individual and his community; to improve the health of the individual and make the community a more healthful and desirable place in which to live. He then stated the benefits which have already been de-

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rived since this organization had been in effect, naming Blue Cross-Blue Shield, Farm Bureau and Grange sickness insurance; Hill-Burton aid to hospital construction; placement service for physicians in communities wanting doctors; state programs providing graduate instruction to rural physicians unable to leave their practice to take refresher courses; organization of state and county health councils; organization of rural committees by state and county medical societies, addition of health educators to land grant colleges, local health surveys by lay personnel and many other things which have formed our highway to health. In taking a look ahead, he justifiably states that now our theme is "Widening the Highway to Health". There were many inspirational talks given during the course of the two days both by leaders in the medical and dental field, by the leaders of the farm groups, by recipients of community planned and executed clinic and hospital facilities, etc. The summary of these lectures was given by Beatty H. Dimit, Master of the Pennsylvania State Grange. He stated that the most striking thing about the Conference was the fact that the cooperation between the medical group and the farm group indicated that the farmer was doing something WITH the medical group, and not having something done FOR him. He said that they would go home to tackle the job of working together to "Widen the Highway to Health" and be strengthened by the example of the members of the Council on Rural Health who are attempting to continue the spirit of the beloved country doctor. Mrs. Ralph Eusden brought greetings from the Woman's Auxiliary to the American Medical Association, and Dr. Louis H. Bauer, president of the American Medical Association explained to the group "What Medicine Is Doing". In the closing of the Conference he stated "The Association wants to be of help to you in any way it can, not only in the rural areas, but in the municipal areas. Its only excuse for being is that of service to the public."

SUMMARY

I

PROCUREMENT OF PHYSICIANS FOR RURAL AREAS

- A. BROCHURE—this has been finished and released. The Indiana State Medical Association was honored by the fact that the American Medical Association asked for copies for distribution to other states.
- B. COMMUNITY BULLETIN—starting in August the committee is mailing through the Headquarters Office to all communities requesting physicians a monthly list giving names and addresses of all physicians who

have made inquiry regarding possible openings in the state.

- C. LECTURE FOR CLASSES AT INDIANA UNIVERSITY MEDICAL SCHOOL—unless otherwise directed by the House of Delegates, these will be dropped in favor of a social gathering where all members of the Rural Health Committee and their wives will be host to the members of the Senior class and their wives.

- D. PHYSICIAN PLACEMENT—starting in September THE JOURNAL of the Indiana State Medical Association will carry a section listing doctors available and community openings.

II

REGIONAL CONFERENCES

It seems that the efforts of the committee, and of the State Officers to bring a working knowledge of the affairs of the organization and a discussion of the doctor's problems to the regional level was not eminently satisfactory during the past year. The discussions were excellent and greatly enjoyed by the few who attended, but the attendance for the most part was poor. The committee would suggest that the House of Delegates direct the various Districts to set aside not less than one hour at their District meeting in which there may be a discussion between the members of that district and their State Officers and Headquarters staff.

III

HEALTH WORKSHOPS

These have served a fine purpose, but it is now the thought of the committee that they should be brought to a county level as a Medical Forum similar to those reported from other states. These entail the cooperation of the press, and of the Woman's Auxiliaries. It is noted that the workshops had better attendance in smaller communities. At the regular meeting of the Council on July 19, 1953 permission was granted for a series of Medical Forums to be conducted at the county level in an attempt to reach more people. It is the wish of the committee that once these plans are formulated and in the hands of the county societies, that they be given a directive from the House of Delegates to see that these meetings are carried forward during the fall and winter months.

IV

HEALTH CONFERENCE AT PURDUE

It is hoped that in the future, when the newly organized Foundation for Community Health gets on its feet, that the Health Conference may be

held under its sponsorship. It seems that the measure of recognition given to the Medical Association is not commensurate with the amount of financial and instructional aid given at Purdue.

V

INDIANA FOUNDATION FOR COMMUNITY HEALTH

Organized June 18, 1953. President is Mr. Henry Heine of the Indiana Pharmaceutical Association. The purpose is to foster like organizations at the county level for the integration and guidance of local health agencies.

VI

NEW PROBLEMS

It seems that with everyone working feverishly to try to get doctors in rural areas, that present Indiana Licensure Regulations are throwing some needless stumbling blocks in the path of this activity in our state by making it difficult in some instances for an out-of-state physician to obtain a license so he might practice in this state. We recommend some method of contact be made with

the licensing board to determine if some of the regulations might be modified without jeopardizing the licensing law.

The Rural Health Committee of ISMA respectfully submits the above report and asks that the following things be improved and implemented:

Medical Forums

Formation of County Health Councils

Appointment of composite Community Health Committees in county medical societies to deal with all health problems of the community in school health, radio transcriptions concerning health, etc.

J. E. DUDDING, M.D., *Chairman*

L. E. HOW, M.D.

R. W. KUHN, M.D.

ELI GOODMAN, M.D.

JOHN BRETZ, M.D.

SAM ROTMAN, M.D.

PAUL B. CASEBEER, M.D.

RAYMOND G. GEICK, M.D.

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Superintendent and Secretary

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State Hospital Association*

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COMMITTEE ON PRECEPTORSHIPS

The Committee on Preceptorships has been very active during the past year. The first meeting was held in Indianapolis on February 1, 1953, at which time a program was formulated and was published in the Indiana State JOURNAL listing the proceedings of the Interim Session of the House of Delegates April 26, 1953.

Four members of this committee, Doctors Kahler, Portteus, Dudding and Bibler met with the Executive Council of the Indiana University School of Medicine on May 7, 1953, and presented a plan of Preceptorships for senior medical students for their consideration. This plan has been approved and pilot programs will start beginning with the September term at the Indiana University School of Medicine.

It is recommended that this Committee on Preceptorships be continued.

The chairman wishes to thank all the members of the Committee on Preceptorships as well as all other doctors interested in this program for their helpfulness and their untiring efforts in behalf of this program.

LESTER D. BIBLER, M.D., *Chairman*

MAURICE V. KAHLER, M.D.

WALTER L. PORTEUS, M.D.

CHARLES ALVEY, M.D.

JOSEPH H. E. DUDDING, M.D.

JOHN D. VAN NUYS, M.D.

COMMITTEE ON ALCOHOLICS STUDY

Our committee met on November 23, 1952, at which time a bill concerning alcoholics and drug addicts prepared by Mr. Albert Stump was considered. This bill was prepared by Mr. Stump at the request of the committee and he was given copies of acts concerning alcoholism that have been passed by Florida, Michigan, New York, Kentucky and Louisiana, to be studied and used as an aid in preparing the bill.

The bill in essence provided for: (1) a program for the rehabilitation of alcoholics and drug addicts through the use of medical, psychiatric, and other forms of treatment; (2) plans to decrease the amount of excessive drinking and use of drugs; (3) reduction of the financial burden imposed upon the people of Indiana by drunkenness and drug addiction; (4) undertaking to do all of this through the substitution of scientific medical methods of treatment in place of punishment through jail sentences and fines.

It provided that a council on alcoholism be created as part of the State Board of Health and that the members be appointed by the Governor.

It provided that alcoholics could be committed to public and private hospitals for treatment through action of all Circuit, Superior, Probate, Criminal, and Juvenile Courts. Application for commitment by the court for treatment could be filed by husband, wife, son, daughter, mother, father, sister, brother, Director of County Public Welfare, as well as the prosecuting attorney. The alcoholic would have the right of appeal to the Appellate Court and transferable to the Supreme Court of Indiana and the right of trial by jury upon request of the defendant.

It provided that the period of commitment shall be for any length of time the Judge finds upon medical testimony to be adequate for the treatment and rehabilitation of the alcoholic, but in no case for more than six months.

Your Alcoholic Committee studied this bill and made recommendations as to who should constitute members of the Council and further suggested that drug addicts be entirely divorced from the Alcoholic Bill. After these changes were made the bill was introduced into the State Senate by Senator Harold O. Burnett. The bill was referred to the Senate Committee on Public Policy, and your chairman of the Alcoholic Committee, Mr. Albert Stump, Doctor Rollo Harger, and others appeared in favor of the bill.

This bill was referred to the Senate without any changes of consequence and was passed by the Senate.

In the House of Representatives the bill was referred to the Committee on Public Morals. In this committee there were radical changes made. The amended bill was then passed by the General Assembly.

Your Alcoholic Study Committee was encouraged by the act passed by the General Assembly in that the act authorizes Courts of the State of Indiana to take judicial notice of the fact that an alcoholic is a sick person and in need of proper medical, advisory and other rehabilitative treatment.

It provides that the Council appointed by the Governor should establish in state institutions, clinics or departments for the diagnosis, classification, hospitalization and proper treatment of the people under the act, found to be alcoholics.

It provides that the Circuit, Superior, Probate, Criminal, and Juvenile Courts can hear and decide cases under the act for the purpose of determining whether a person brought before the court is an alcoholic. Any resident of the State of Indiana who believes himself to be an alcoholic can file an application to any of the above courts and then this alcoholic can be committed by the court for medical treatment at a state institution.

Your committee feels that by the changes made in the bill omitting the right of the interested parties to file applications to the court to provide

treatment for the alcoholic, that many alcoholics that need treatment will go untreated since this stipulation was deleted from the bill.

Your committee feels that it has helped in getting the General Assembly of the State of Indiana to pass an act to recognize the alcoholic as a sick person and to provide a place for the scientific treatment of such a person.

We feel that this is only the beginning and that the committee has much more work to do in helping solve the problems of the chronic alcoholic. This committee should make constructive suggestions to the Council appointed by the Governor. It should give all available scientific information concerning chronic alcoholism; it should encourage a campaign of education of the general public, especially high school and college students, concerning the danger of the excessive use of alcoholic beverages; and should attempt to get more beds and facilities available for the scientific treatment of these individuals.

This committee wishes to express its thanks for the assistance given by the Committee on Public Policy and Legislation in obtaining the first constructive act passed by the General Assembly of Indiana to deal with the alcoholic problem.

LOWELL F. BEGGS, M.D., *Chairman*
PAUL LONG, M.D.
HOWARD W. BEAVER, M.D.
C. PHILIP FOX, M.D.
C. W. CULLNANE, M.D.
CARL M. HOSTETTLER, M.D.
KENNETH BROSHEARS, M.D.

COMMITTEE ON ANTI-NATIONAL HEALTH INSURANCE

The Committee recommends that this committee be discharged and the duties of the committee assigned to the Committee on Public Relations. This is recommended in keeping with the policy established by the American Medical Association of turning over to their Public Relations Department the duties formerly performed by the firm of Whitaker and Baxter. It would seem we should follow this lead in order to better coordinate the program between the AMA and our Association.

Our committee held one meeting this year at the time of the Interim Session of the Indiana State Medical Association, April 26, 1953. At that time the problem was stated as it had been put up to us by President Paul D. Crimm, that our committee was more or less on a stand-by basis, in order to be ready in case there was any threat toward a program of national compulsory health insurance or socialized medicine under whatever guise it was introduced.

I am happy to say there has been no serious threat along these lines introduced this year, so

that we have merely kept track of things and have not felt that any outlay of funds was necessary for newspaper or radio advertising such as formerly seemed appropriate to the predecessor of this committee,—The A.M.A. Campaign Coordinating Committee. Some expenditures along the lines of public relations have been debited from this committee's budget, but otherwise there has been no activity necessary.

This committee's activity or the lack of it suggest two possible lines of thought:

1. In line with the discussion as to whether to abolish the interim session, it does make a good opportunity and occasion for policy committee meetings.

2. In view of the lack of need for unusual expenditure to fight socialized medicine, it may be considered timely to suggest lowering the dues of the state organization, even if only temporarily.

ELTON R. CLARKE, M.D., *Chairman*
LAWRENCE S. BAILEY, M.D.
HERMAN BAKER, M.D.
J. R. DOTY, M.D.
T. R. HAYES, M.D.
G. O. LARSON, M.D.
C. A. NAFE, M.D.
WALTER PORTEUS, M.D.
V. EARLE WISEMAN, M.D.
JOHN A. LARSON, M.D.

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AUDITING COMMITTEE

The annual meeting of the Auditing Committee was held on July 24, 1953, at the Indiana National Bank, Indianapolis. The investments of the association were examined in detail and are listed below.

General Fund:

United States Savings Bonds, Series G--	\$ 46,000.00
United States Savings Bonds, Series K--	25,000.00
United States Treasury Bonds -----	65,000.00
United States Treasury Certificates of	
Indebtedness -----	30,000.00
	<hr/>
	\$166,000.00

Medical Defense Fund:

United States Savings Bonds, Series G--	\$ 13,000.00
United States Savings Bonds, Series K--	1,000.00
United States Treasury Bonds -----	5,000.00
	<hr/>
	\$ 19,000.00

Bank statements of cash balances, as of June 30, 1953, in the Indiana National Bank, the American National Bank, the Fletcher Trust Company, and the Bankers Trust Company were examined by the committee. These accounts consist of the General Headquarters Office Fund, the Medical Defense Fund, THE JOURNAL Fund, and the Petty Cash Fund, respectively, and showed the following balances:

General Fund -----	\$112,967.33
Medical Defense Fund -----	7,942.15
THE JOURNAL Fund -----	13,453.04
Petty Cash Fund -----	582.46
	<hr/>
	\$134,944.98

- WEMPLE DODDS, M.D., *Chairman*
- ROY V. MYERS, M.D.
- THOMAS C. BROWN, M.D.
- F. W. MESSER, M.D.
- ROY A. GEIDER, M.D.
- CHARLES OVERPECK, M.D.

COMMITTEE ON CANCER

The Committee on Cancer met 26 July 1953 at the Columbia Club, Indianapolis. Members present were: Drs. W. D. Gatch, Indianapolis; George A. May, Madison; Mell B. Welborn, Evansville; and the Chairman.

It was the feeling of the committee that educational efforts by all groups interested in cancer might well place greater emphasis on the more frequent employment of diagnostic curettage with endometrial and cervical biopsies in any patients who present abnormal vaginal bleeding. Although this has been stressed in the past there has been some hesitancy on the part of the profession apparently to employ it as extensively as it might be advantageously done. This diagnostic procedure may be very valuable in those patients near the menopause, or for that matter in any patient with unexplained bleeding.

The committee feels that the present trend toward the greater use of total hysterectomy is a proper one. Every careful analysis of any long series of uterine operations will develop a certain number of late malignancies in cervixes left in situ.

The committee also feels that some breast biopsies may have been too restricted and that a wider excision of tissue might have revealed malignant cells. It was also noted that the positive identification of cystic mastitis does not rule out concomitant malignancy elsewhere in the breast.

The committee reiterated the frequently expressed dictum that cancer will be found, in any organ of the body, in proportion to the zeal of the examining physician. Each of us will have done his duty only when he has excluded the possibility of malignancy in any investigation of any complaint the patient may have. It was recognized, of course, that a few large centers for the management of neoplastic disease may be advantageous for investigative work, but that the great bulk of definitive therapy must, and should be carried out by the practicing profession at large.

The committee recognizes with gratitude the good effects of publicity on cancer by the several lay groups devoting so much of their energy, time and money. Undoubtedly these efforts are bringing cancer out of the dark recesses of ignorance and to some degree shame, and thus helping the profession to get these cases of cancer earlier and at a stage when much can be done. However, the committee wonders whether all this publicity is always having the effect that we desire it to, for at least in some instances patients seem to be driven to such fear of cancer that they will not

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consult their family physician because of dread of what he might find. The committee feels that the emphasis of publicity should be on cure rather than on the horror of the disease.

PARVIN M. DAVIS, M.D., *Chairman*
 R. B. STOUT, M.D.
 GEORGE A. MAY, M.D.
 L. W. ELSTON, M.D.
 W. D. GATCH, M.D.
 DAVID A. BICKEL, M.D.
 MELL B. WELBORN, M.D.
 F. J. KLEINMAN, M.D.

COMMITTEE ON CHRONIC ILLNESS

The Committee on Chronic Illness of the Indiana State Medical Association met at the Columbia Club, Indianapolis, on Sunday, March 29, 1953, at 10 a.m. Present were Drs. Stuart Combs, Chairman of the Committee on Heart Disease; Wendell Anderson, Director, Gerontology and Chronic Diseases of the Indiana State Board of Health as invited guests. Seven members of the committee were present.

Two hours were spent reviewing the minutes of preceding Committee on Chronic Illness, and the Indiana Committee on Chronic Illness, plus the Proceedings of the Conference on Preventive As-

pects of Chronic Disease, this material having been supplied the committee members in advance of this meeting. All present participated in discussion.

After luncheon, the meeting reconvened and formulated the following outline of the Chronic Illness problem:

OBJECTIVES:

- I. Prevent
- II. Find
- III. Rehabilitate
- IV. Care for Elaboration on Objectives

I. PREVENTION

Education of people as a whole to prevent Chronic Illness. Must include environmental facts, diet, housing, hygiene, accident prevention, etc.

II. FINDING

1. Education of people as to symptoms indicating possible disease.
2. Make each practicing physician's office a detection center.
3. Study methods of mass screening now in existence, and those to be developed. Keep informed professionally.
4. Use of existing agencies and social health

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services to report any evidence or existence of Chronic Illness.

III. REHABILITATION

1. Education of people as to facilities available, and results to be accomplished.
2. Use of existing agencies of vocational rehabilitation.
3. Employment of handicapped.
4. Adequate care, including medical care during convalescence. Economic facts must be considered and solved.

IV. CARING FOR THOSE WHO CANNOT BE REHABILITATED

1. Home. Training of member of family in proper care.
2. Nursing and convalescent homes. (Adequate standards).
3. Fraternal and religious institutions.
4. County homes and/or infirmaries. Present standards in general are very poor.

MEANS OF ATTAINING THESE OBJECTIVES:

1. Further aid and support of existing Committees of Medical Associations on specific illnesses (Cancer, Tuberculosis, Diabetes, Heart).

It was suggested that the Committee on Chronic Illness in the future might include the Chairman or his designated representative, of the Committees on Tuberculosis, Cancer, Diabetes, Heart Disease etc., as these are all included in the Chronic Illness problem.

2. Cooperation with existing voluntary health agencies.
3. Research.

It must be kept in mind that EDUCATION is the most important feature of all phases of the Chronic Illness problem.

The following points must be considered in order to attain the objectives outlined above:

1. Means of education, as press, radio, existing groups (P.T.A., Farm Bureau, Home Economics clubs, labor groups, plant management). The continued education of physicians and allied professions is also a necessary aspect of the Chronic Illness problem.
2. Screening programs. These require much study and coordination.
3. Lay program of self-evaluation of health.
4. Expansion of the work of local and state-wide agencies in rehabilitation work, also

the expansion of employment opportunities for the handicapped.

5. Improving means of caring for those who cannot be rehabilitated.

A. Nursing Homes:

Active support of the State Association of Nursing Homes and their program of self-improvement.

The association is to be commended for instituting a series of short courses for nursing home operators at the Indiana University Medical Center.

B. County Homes and/or infirmaries:

The majority of counties can no longer economically support proper facilities for the medical and nursing care of the indigent chronically ill. The principles of the "County Poor Farm" are no longer valid. The tendency toward grouping such cases in larger institutions on a regional basis leads to more adequate care and rehabilitation when possible.

Existing County Homes are advised to:

1. Assign to one physician the responsibility of medical care in the home, who should visit the home at regularly scheduled intervals for the health supervision of all the residents.
2. A thorough initial examination should be done by the physician in charge, for a health evaluation of the individual upon admission.
3. A medical record should be kept on each individual giving his current status of health, and medications given.
4. Written standing orders for routine and emergency procedures should be prepared by the physicians for the guidance and protection of the superintendent and matron of the institution.

No further meetings of this committee were held during this year.

CHARLES N. MANLEY, M.D., *Chairman*

WARREN C. HASTINGS, M.D.

R. K. WEBSTER, M.D.

PAUL A. CLOUSE, M.D.

W. K. NANCE, M.D.

JUSTIN R. NASH, M.D.

MARVIN MCCLAIN, M.D.

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COMMITTEE ON CIVIL DEFENSE

Early in the year, the Indiana Association of Clinical Pathologists, which has been acting as an advisory group on the blood and plasma procurement program for civil defense, asked to be relieved from considering plasma expanders. Our Committee, therefore, went into this problem because the state wished to be advised whether to purchase expanders as a part of our State Medical Civil Defense stockpile. The two expanders which have been favorably considered by Federal Civil Defense are P.V.P. or Polyvinylpyrrolidone, which is a synthetic water soluble polymer developed by the Germans and used in World War II; and Dextran which is a by-product of the sugar beet refining industry. According to a report in December 1952, the National Securities Resources Board has not yet approved either of these expanders since an ideal molecular weight for prolonged action as a plasma expander has not yet been achieved in either of these products. Since it seemed possible that improvement might be made or other more satisfactory expanders found, the Committee recommended that no purchases for State Civil Defense stockpiling should be made in 1953.

The Committee has given particular attention to the problem of mobile medical support in the State Medical Civil Defense organization and operational planning. Mobile support is the organization of medical units of a size capable of operating a mobile field evacuation hospital such as was operated by the Army in World War II; such units to assemble upon a call from State Mobile Support Civil Defense Headquarters and to report for duty in the area of a city which has been subjected to an atomic bomb attack. The need for such units is based upon federal and state civil defense planning and on the tenets that: 1. To save lives, emergency medical care must be carried as near to the patients as possible, and 2. The total expanded hospital capacity (with each general hospital in the state having planned, by the use of auxiliary hospital facilities, to expand to five times their existing general bed capacity) will still require that 35 percent of the casualties from an atomic bombing in a major target area be hospitalized and treated in the environs of the target city. The Committee concludes that medical mobile support units, in addition to other medical civil defense planning, must be organized from the medical and allied professional groups in each major target area, namely: Allen County, Lake County, Marion County, St. Joseph County and Vanderburgh County. Mobile support units must also be organized in secondary target areas such as; Lafayette, Muncie, Anderson, Richmond, Terre Haute, Jeffersonville, New Albany and Marion. Such organization to be in addition to their plans to expand to five times their existing hospital general bed

capacity to receive and care for casualties evacuated from the target area.

The Committee has followed the stockpiling and preparation of medical first-aid kits which are to be distributed to each of the five major target areas, some to other counties which have contributed matching funds for the purchase of first-aid kits and a portion to be held in state stockpiles which will be strategically located in state institutions about the state. At present the cartons for these kits and their packaging are in progress and they should be distributed on or about October 1, 1953. Each first-aid unit cost \$544.74, and is expected to provide for the need of 700 patients in a first-aid station for the first 24 hours. Thereafter, supplies from federal regional civil defense stockpiles should supply replacements.

The Chairman of the Committee attended, as an official representative of Indiana State Medical Association, a two-day conference on civil defense conducted by the Emergency Manpower Council in conjunction with the A.M.A. meeting in New York. Mr. Val Peterson, the new Director of Civil Defense, addressed this meeting and took note of the fact that there is a general lagging of interest in civil defense but emphasized that the medical civil defense organization must keep itself organized and prepared to handle local civil disasters in conjunction with the Red Cross, and must be ready at all times to perform its major functions should an atomic attack occur. "When the bomb falls people will yell, 'Where's a Doctor'—not, 'Where is the Fire Department, the Public Health Department' and etc.," he said. Reports were made on the Federal Civil Defense organization, the present status of federal stockpiling, new information on nerve gas, reports on the experience in the Nevada tests, current planning for training bulletins for first-aid workers, industry's stake in civil defense organization and numerous reports and discussions on problems and experiences of various states regarding medical civil defense organization. One point was garnered from the New York report which relieves a worry and will probably save the state thousands of dollars.

Federal Civil Defense required that penicillin in oil be purchased for first-aid kits. Since such a preparation is not now generally used, no possible means of rotating this stock had been found by us, however, New York has been running assays on their stocks of penicillin in oil and reports that the potency of the penicillin is maintained considerably beyond the expiration date stamped by the manufacturer. They recommend that samples from lots be submitted to the manufacturer for assay, thereby, relieving the necessity for rotation.

On the second day, a demonstration of a Medical Civil Defense organization by an industry was put on by the Metropolitan Life Insurance Company. They have 80 first-aid workers, who have

been trained on company time, for two years. They have also worked out a very elaborate scheme of "safe areas" in their two blocks of buildings to be used as bomb shelters; and first-aid and fire-control teams on each floor of their buildings. Hospital areas are marked and supplies on hand. Emergency power and emergency telephone lines which do not parallel the regular circuits have been put in. A disaster control center has been selected by engineers and is stocked with food, air conditioning, and a complete staff organized and assigned. We were also shown the collapsible aluminum framed litters and slings with which the ordinary transit buses in New York City have been equipped so that they can serve as emergency mass ambulances capable of transporting 32 patients.

The Committee feels there is not enough coordination of the Medical Civil Defense organization under the State Civil Defense organization and suggests for consideration, that a Section on Civil Defense be organized and meet as a part of each year's State Association Convention.

GLEN WARD LEE, M.D., *Chairman*

T. D. ARMSTRONG, M.D.

E. W. BAILEY, M.D.

W. O. BALDBRIDGE, M.D.

JEAN V. CARTER, M.D.

CLAUDE D. HOLMES, M.D.

JAMES E. JOBES, M.D.

JAMES M. LEFFEL, M.D.

K. L. OLSEN, M.D.

PAUL W. SPARKS, M.D.

WALTER R. SPRINGSTUN, M.D.

COMMITTEE ON CONSERVATION OF VISION

A meeting of the Conservation of Vision Committee was held at McCormick's Creek State Park prior to the annual meeting of the Indiana Academy of Ophthalmology and Otolaryngology, May 6, 1953. The following were present: Edwin Dyar, M.D., Indianapolis; Noel McBride, M.D., Terre Haute; Robert Smith, M.D., New Castle; and Carl J. Rudolph, M.D., South Bend, chairman.

In spite of an accelerated schedule being adhered to, a good two hours were employed in reviewing the business at hand. It was the unanimous opinion of the Committee that to consummate a major objective it would be necessary to join forces with all organizations concerned with a similar purpose. This meeting was planned for July 26 and was subsequently held on this date in the Columbia Club, Indianapolis. The four major

objectives were agreed upon and appear as exhibit A in the minutes of that meeting.

On July 26, 1953, the committee met in Indianapolis with the following members present: Jeanne Rybolt, M.D., Indiana State Board of Health; Edwin Dyar, M.D., Chairman, Section of Ophthalmology and Otolaryngology, Indiana State Medical Association; Robert A. Smith, M.D., President, Indiana Academy of Ophthalmology; Dr. Henry H. Hofstetter, Director, I. U. School of Optometry, Bloomington; Dr. Robert Tubesing, President Indiana Optometric Association and member of the Executive Council of the American Academy of Optometry; Dr. John P. Davey, Chairman, Committee on Inter-Professional Relations of the Indiana Optometric Association; Dr. Dan Elliott, President-elect of Indiana Chapter of the American Academy of Optometry; Carl J. Rudolph, M.D., Chairman, Committee on Conservation of Vision, Indiana State Medical Association.

Non-members present were: Jas. A. Waggener, executive secretary, Indiana State Medical Association, and Albert Stump, attorney for the Indiana State Medical Association.

The meeting was called to order by Doctor Rudolph. There being no regular secretary and the special one who was expected to attend not being present, Mr. Stump volunteered to act as secretary and take such notes of the meeting as he was able to and then write up the minutes therefrom. His offer was unanimously accepted.

Doctor Rudolph stated that the purpose of the meeting was the coordination of the efforts and potentialities of all the groups represented, to improve their service in the care of the eyes and protect the public against incompetent service, fraud and imposition,—to the end that there may be better conservation of sight in the interest of the welfare of the entire public.

Doctor Rudolph and his committee at their May 6, 1953 meeting had prepared a statement of four subjects for discussion, a copy of that statement is made a part of these minutes and attached hereto as Exhibit A.

The subjects included in the statement were taken up in the order in which they are stated in that document.

After reading subject No. 1, Dr. Davey spoke of the kind of advertising referred to therein as being illustrated by the advertising in an Indianapolis paper of one company which is trying to increase its sale of glasses through recommendations of non-professional persons whom the company hires to make eye examinations and then recommend that company's glasses. A postal card sent through the mail by this company as a part of its obvious plan to obtain business in the manner above mentioned was then read and discussed.

The question of advertising of prices and of other alleged factual matters in connection with the glasses and of further means through which

the company might, or was attempting to, draw doctors into the operation of their business, was also considered.

In this connection the possibility of an injunction against the company above referred to to prevent the conduct of its business in a manner which its advertising seemed to indicate, was mentioned and the suggestion was made that the attorney for the Optometrists make a study of the legal possibilities through injunctive or other legal procedures. The question was also discussed in relation to this possible injunctive relief, of suspending or revoking licenses of physicians who cooperate in carrying out any plan of that company, or anyone else, which involves misrepresentation and imposition upon the public. Mr. Stump expressed the tentative view that both the injunction procedure and the revocation or suspension of license would be available. But he further said that before advising definitely that either course be followed he would want to make a further study of the applicable law or have the benefit of the study of someone else on that question. He suggested that this question be taken up with Mr. Pell, of Shelbyville, the regular attorney for the Optometry Society.

Doctor Rybolt was asked what possibilities of preventing the type of fraud that had already engaged the attention of this meeting, existed in the Board of Health. She spoke of the general theory and practice of the Board to work through educational means for the elevation of the standards of practice involving the health of anyone, rather than through efforts to compel any specific conduct through recourse to litigation. She also emphasized the desirability of cooperation of all professions interested in health matters, and informed the meeting of the readiness of the Board of Health to be of help in such enterprises wherever possible.

Dr. Davey then took up the discussion of the need of better inter-professional relationships. It was the consensus of the meeting that something should be done by the Committee to help satisfy this need.

Attention was called by the chairman to the fact that the discussions growing out of the first subject had naturally expanded to include much of what was covered in the second subject. The second subject was then read. It was the consensus of opinion that further investigation should be made as to the possibilities within the existing laws which provided for the adoption of rules and regulations by the Board of Health, the Board of Optometry, and the Board of Medical Registration and Examination; and that if the possibilities within the rule-making power of these boards were sufficient, to work through those possibilities rather than to attempt to achieve the same results by a legislative program,—since legislative programs are generally difficult to carry out in the original form intended, and also have the tendency

to open the door to undesirable legislative efforts which confuse and sometimes thwart the program of those who undertook to obtain such legislation.

The meeting then took up the discussion of the unfortunate developments occurring in the field of the sale of safety glasses. In this connection the third subject was read. The work of the Optometrical Society of Indiana came in for general criticism as the work of a highly commercialized few whose efforts should be discouraged. Attention was called to the fact that this organization obviously was given a name by its promoters which they intended would cause the public to confuse it with the Indiana Optometrical Society; and that this presented a problem for further study.

The channeling of safety glass business to certain dealers for pay was condemned by the consensus of the meeting. The possibility of educating the public to know and look for good safety glasses was talked of at some length. In this connection comments were made upon the fact that the U. S. Bureau of Standards had already defined "safety glasses" and thereby established standardization of safety glasses by definition, although this standard was not being complied with in all instances,—which presents a question of enforcements that ought to be further considered.

Doctor Rudolph spoke of the desirability of having civilian lenses standardized to eliminate wide variations in what are sold as first quality lenses. The possibility of accomplishing this through definition by the U. S. Bureau of Standards was also suggested.

Doctor Rybolt was then requested to report on the work of the State Board of Health on the conservation of sight. Her report was received with approval and the suggestion was made that she make the material of this report available to all the members of the committee which she thought could be done. Doctor Dyar commented upon the report and spoke of the improving of this work as one of the most important projects that could engage the efforts of this Committee and the organizations represented in it.

A letter from Dr. Nester to Dr. Ochsner regarding syphilitic optic atrophy was brought before the meeting by Dr. Tubesing. He stressed the importance of an educational program being worked out covering the subject of the handling of this type of disease, in the conservation of vision. The question was raised as to statistics regarding this condition. Doctor Rybolt informed the meeting that statistics in this field were obtainable from Dr. Rutherford in the State Department of Public Welfare.

Adverting again to the type of glasses that should be made available to the State of Indiana, and their standardization under some known designation, subject No. 4 was read to the committee and met with general approval.

The chairman, Doctor Rudolph, then expressed his appreciation of the attendance of all who were present, and stated that he would like to have a report of this meeting given to each member for their further study in working out a more definite program to be undertaken in the future. He expressed pleasure at the amount that was accomplished in getting these matters into the realm of discussion and interest on the part of the representatives of the various groups cooperating in the conservation of sight.

The meeting expressed its appreciation of the service of the Indiana State Medical Association in arranging for this meeting and inviting the members to attend as its luncheon guests. Spokesmen of the various groups represented warmly complimented all who attended on the splendid spirit which prevailed and on the mutual interests of all in future meetings designed to better coordinate their activities.

There being no further business to come before the meeting it adjourned.

EXHIBIT A

1. Prohibit professional advertising in the State of Indiana as it is not in keeping with the ethics of the professions and encourages the uninformed laity to consult those of questionable character who take an advantage of such a medium rather than depending on the virtue and merits of their own professional care for the public to establish themselves. Their advertising in newspapers of high character and established reputation gives credence to statements therein that the public ordinarily would ignore had it not the apparent endorsement of a medium published by men of unquestionable reputation.

2. Optometrists have secured legislation forbidding one of their members advertising prices. This discourages connections with companies of questionable repute. Consequently these organizations have turned to the medical profession and solicit M.D.'s whom they hire as a front for a nefarious practice at the expense of the public for the organization's own personal profit. Legislation should be encouraged so this honorable profession could divorce itself from such practices and not be a shield for organizations who use us as a loophole in the law which otherwise would terminate their activities.

3. Industry should be advised that it would be

to their advantage to have safety glasses periodically checked, that is every one to three years. It is becoming increasingly apparent that key personnel for a consideration are channeling employees to the highest bidder for prescription ground safety glasses. The state Committee for the Conservation of Vision has reason to believe many of these glasses are substandard and do not meet with specifications; this will unnecessarily jeopardize the eyes of the employees which is of paramount interest. Trafficking in human welfare does not lead to quality merchandise.

4. In the interest of the public and their physical well being it is imminent that substandard glasses of all types should be made unavailable in the State of Indiana. First quality lenses should meet with the standards set up by Bausch and Lomb or American Optical Companies and should not subscribe to a definition of a so-called first quality lens made by an organization of questionable reputation. Their first quality lens may compare favorably with a third quality lens manufactured by a reputable house.

CARL J. RUDOLPH, M.D., *Chairman*

NOEL MCBRIDE, M.D.

E. W. DYAR, M.D.

EDWARD U. MURPHY, M.D.

E. L. VAN BUSKIRK, M.D.

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COMMITTEE ON CRIPPLED CHILDREN SERVICES

Approximately six months ago I wrote to each member of my Committee on Crippled Children Services, and asked them for any suggestions as to improvements or corrections of existing problems. Those from whom I received a reply stated that there were no problems, or if there were any they were being taken care of without any trouble. I trust this brief report is satisfactory.

LEO K. COOPER, M.D., *Chairman*
 JOHN W. RIPLEY, M.D.
 WAYNE R. GLOCK, M.D.
 LELAND G. BROWN, M.D.
 EDWARD T. STAHL, M.D.
 J. S. BROWN, M.D.
 L. A. ENSMINGER, M.D.

COMMITTEE ON DIABETES

The Diabetes committee has had one meeting during the year at which time the matter of co-operation in the National Diabetes Detection Drive was discussed.

It was the feeling of the committee that every effort should be made to encourage the component societies of the Indiana State Medical Association to participate in this drive, (1) because of its important public relations value, (2) in order to do our share in locating the unknown diabetics.

Previous methods of conducting these drives were discussed as was the new plan utilizing Drey-Paks, a method tested out by the Indianapolis Medical Society in 1952 and found to be satisfactory.

Contact was made with the National Diabetes Association where it was learned that Drey-Paks would be available in limited quantity for the 1953 drive and could be obtained at a price of one to one and one-half cent each.

In view of this the committee conducted a sur-

vey of all component societies asking which would or would not cooperate in the 1953 drive.

Following this survey, a follow-up letter was sent to those counties stating they would cooperate, calling to their attention the availability of Drey-Pak.

Letters were prepared to those societies who stated they did not plan to cooperate and to those from whom no word was received, in which it was urged that they reconsider their action and plan to participate in the drive. The availability of Drey-Pak was also called to their attention, and samples of this new method were sent to all county societies.

In both letters the committee urged the following as a basis for a suggested local detection drive.

1. Contact manufacturers, businessmen, women's organizations, labor groups, and suggest they cooperate with the society in a detection drive, by being responsible for the distribution and collection of Drey-Paks.
2. If the community was an industrial one that the society talk to management and labor leaders asking their cooperation in making the test available to all employees, and if necessary seek their assistance in underwriting the cost of the supplies for the drive.
3. That it would be a good public relations gesture on the part of the society to offer this service at no cost to the community, but if requirements were so great as to make the cost prohibitive to the society, then we recommended that cost be shared by the society and management.
4. That arrangements be made with the local hospital, or laboratory to develop the tests, once they were collected.
5. That special emphasis be placed on an effort to obtain cooperation from people 50 years of age and over in the drive.

At the time this report was written, it was impossible to give an accurate report of the results of this effort, but indications were that only spotted cooperation was to be had throughout the state.

Your committee feels this annual detection drive should be called to the attention of the members of this Association and that they be urged in the future to participate more fully in this effort.

D. D. DICKSON, M.D., *Chairman*
 L. F. GWALTNEY, M.D.
 S. L. BRYAN, M.D.
 JAMES P. VYE, M.D.
 FREDERIC M. DUKES, M.D.
 RAY ELLEDGE, M.D.

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COMMITTEE ON FOOT HYGIENE

No Report.

COMMITTEE ON HARD OF HEARING

1. The committee recommends that the name of this committee be changed to be the Committee for the Conservation of Hearing.

It is further recommended that this committee sponsor a luncheon at the annual meeting of the State Medical Association better to inform other members of the profession of the activities of this group.

2. In order to implement those recommendations made previously by this Committee it is urged that an interchange of consultants be arranged between the Indiana Speech and Hearing Therapists' Association and the Ear, Nose and Throat Section of the Indiana State Board of Health and the Indiana State Department of Public Instruction, working in close relationship with the Indiana Academy of Ophthalmology and Otolaryngology. It is hoped that when these consultants are appointed that they will organize within their group to assist the Committee for the Conservation of Hearing in the preparation of the rehabilitation programs for educational institutions as well as other agencies, governmental and private, interested in hearing conservation. Those governmental agencies interested in hearing conservation have met to discuss their mutual problems, and they are also working towards a cooperative program for good interrelationship between the members of the medical groups and all agencies and groups promoting hearing conservation and speech therapy.

3. We further urge that all physicians become familiar with existing state laws providing for services for hearing—handicapped children and children with other types of disorders which limit their educational adequacy. In 1941 a law was passed by the state Legislature which required audiometric examinations of every public school child, each year. Following these examinations those children who are found defective in hearing acuity and beyond the scope of ordinary medical measures, various phases of educational rehabilitation is to be provided, such as instruction in lip-reading, auditory training and/or hearing aids. This law was an obligatory, not a permissive law. Some communities have fulfilled the letter of the law but too many still ignore it.

4. In 1947 additional legislation was passed which is designed to help the handicapped school child. This law is a supplement to a law passed in 1927. It provides that school corporations are empowered by permissive legislation to establish special education programs for hard-of-hearing,

defective speaking, crippled and sight-loss children. The goal of this law is to enable children to eliminate disorders, whenever possible, which interfere with their education, or to learn compensatory procedures to make up for their deficiencies. The State Department of Education is empowered to pay up to 100 percent of the additional cost of this program to the public school system establishing such a program. The methods for the establishment of such a program are relatively simple, and there is little reason why any community in the state of Indiana should not furnish services which will help in the rehabilitation of its handicapped children. Those officials in each community should write the State Department of Special Education, sending the names of its handicapped children and a brief statement of the nature of each handicap, and request that they be enabled to start a program, with state approval. We feel that it is your obligation to see to it that the handicapped children in your communities get their full share of opportunities available under these laws: Acts 1941, Chapter 212, Page 642; Acts 1927, Chapter 211, Page 599; Acts 1947, Chapter 276, Page 1102.

HUGH A. KUHN, M.D., *Chairman*

C. H. MCCASKEY, M.D.

CARROLL O'ROURKE, M.D.

ROBERT TURGI, M.D.

ROBERT A. SMITH, M.D.

GUY A. OWSLEY, M.D.

J. W. BEGLEY, M.D.

W. E. STEWART, M.D.

COMMITTEE ON HEART DISEASE

In response to the request for an opinion about the necessity of having a meeting of the Heart Committee, letters were received from four members of the committee. The consensus of opinion was that there are no problems at the present time requiring the attention of this committee. Most of the members expressed the opinion that much of our work is being handled by the Indiana Heart Foundation. One member hopes for a closer cooperation with the Indiana Heart Foundation on their research problems.

The committee has no further report to make at this time.

STUART R. COMBS, M.D., *Chairman*

RALPH C. EADES, M.D.

PHILIP W. ROTHROCK, M.D.

PATRICK J. V. CORCORAN, M.D.

WALTER S. FISHER, M.D.

DAN L. URSCHER, M.D.

JOHN F. LING, M.D.

COMMITTEE ON INDIANA INTER-PROFESSIONAL HEALTH COUNCIL

The Committee on Indiana Inter-Professional Health Council has held only one meeting since the 1952 annual convention of the Indiana State Medical Association and the minutes of that meeting constitute the report of the committee for 1953.

The Indiana Inter-Professional Health Council met at the Columbia Club, Indianapolis, Wednesday, November 26, 1952.

Present were: representing the Indiana State Dental Association, E. E. Ewbank, C. T. Mayfield, Ralph E. McDonald, Edward L. Mitchell; representing the Indiana Hospital Association, Bernard F. Carr; representing the Indiana State Medical Association, M. B. Catlett, M. E. Clark, George M. Ellis, James A. Waggener; representing the Indiana State Nurses Association, Genevive Beghtel, William Hartnett, E. Nancy Scramlin, Marie Winkler; representing the Indiana Pharmaceutical Association, Herbert H. Gerding, Henry W. Heine, J. B. Lischke; representing the Indiana Veterinary Medical Association, T. H. Brown, J. W. Green; representing Butler University College of Pharmacy, K. L. Kaufmann; representing Purdue University School of Pharmacy, Glenn L. Jenkins; representing Indiana University School of Medicine, Thurman B. Rice; representing the Indiana State Board of Health, L. E. Burney.

Following lunch, Chairman Jenkins called the meeting to order and oriented new members regarding the aims and purposes of the Council. He also stated that the principal item on the agenda of this meeting was to present and discuss legislative matters member associations are interested in and which are likely to confront the health professions during the forthcoming session of the Indiana Legislature.

Next, Chairman Jenkins called upon representatives of member groups to inform Council members on matters of a legislative nature their respective organizations are concerned with.

Dr. Burney reviewed budget requirements for the State Board of Health covering the next biennium. His remarks were supplemented with a brochure entitled, "A Wise Investment in Public Health", which was distributed to Council members. He also called attention to two new activities of the Board which involve water analyses for the Flood Water Board and diagnostic work in virus diseases. Dr. Burney emphasized the need for trained personnel and salaries that will hold key personnel employed by the State Board of Health. Dr. Catlett moved that the Council and its member associations go on record in support of the budget and personnel needs of the State Board of Health; and to stress to the State Personnel Board the value of good personnel and why higher salaries must be paid to retain such

employees. The motion was seconded by Dr. Ewbank and was approved. Dr. Burney was instructed to prepare a resolution embodying the thoughts of Dr. Catlett's motion and to present it to the secretary.

Mr. Waggener spoke for the medical group and stated that they have no new legislation to present, but that they again anticipate the introduction of a chiropractic bill.

The main objection to chiropractic bills in the past, Mr. Waggener stated, has been that educational requirements did not meet, and have not been comparable with requirements of other health groups and professions. He asked the support of member groups in opposing such a bill.

Miss Scramlin elaborated on a bill the Nurses Association plans to introduce. She pointed out the need for a better nursing program and the upgrading of education and educational facilities. Miss Scramlin said the bill calls for \$100,000 each year during the next biennium for scholarships in nursing and for graduate study in nursing. She supplemented her presentation with charts and graphs showing that the present educational requirements for graduate nursing in Indiana rated lower than those of many other states. Mr. Gerding moved that the Council and its member groups support the nurses program. Mr. Carr seconded the motion which was approved. Miss Scramlin was instructed to prepare a resolution to this effect and to forward it to the secretary of the Council.

Mr. Gerding spoke for pharmacy and informed Council members that the Indiana Pharmaceutical Association in collaboration with the Indiana Board of Pharmacy will introduce a bill which, for the most part, is a codification of the present Pharmacy Law with changes that will up-grade apprenticeship training; include more definitions; clarify some existing provisions of the law; and changes in fee schedule. Following Mr. Gerding's report Dr. Rice moved that the Council endorse the proposed pharmacy code, and recommended that member groups do likewise. The motion was seconded by Dr. Mitchell and was approved. The pharmaceutical group was instructed to prepare a resolution incorporating the intent of the motion.

Dr. Green, representing the Veterinary Medical Association, reviewed the workings of the Livestock Sanitary Board and the need for an increase in its budget to adequately execute present programs and new projects dealing with animal diseases such as tuberculosis, anthrax, brucellosis, etc. He also stated that the Veterinary Medical Practice Act is being re-written, and that a bill covering this will be introduced during the coming session of the Legislature. Approval of the veterinary program was requested by Dr. Green, Dr. Mayfield's motion, seconded by Dr. Brown in support of Dr. Green's request was approved by the Council. Dr. Brown agreed to prepare a resolution relative to support of the veterinary program and

the motion. The resolution is to be transmitted to the secretary.

Dr. Rice, representing the Indiana University School of Medicine, pointed out the need for a new medical building for instruction of medical students. He called attention to the increase from 100 to 150 students now admitted to the freshman class and the additional facilities needed. Dr. Rice moved that all groups represented support the general program as presented by him. Mr. Gerding seconded the motion which was approved. Dr. Rice is to prepare a resolution voicing the Council's approval and submit it to the secretary.

Dr. Kaufman representing Butler University College of Pharmacy stated that they have no specific legislation to present.

Dr. Jenkins, representing Purdue University School of Pharmacy, said that his school has no legislation to present, and that their budget requirements are included in the overall budget for the university.

Mr. Heine called attention to Governor-elect Craig's public statement recommending the consolidation of all boards insofar as possible. Following a brief discussion on this, Mr. Gerding moved that the Council support the present autonomy of boards representing the health professions, and that if a bill should be introduced which calls for the consolidation of all boards, the chairman of the Council shall call a special meeting. The motion was seconded by Dr. Catlett and was approved. If it becomes necessary, Messrs. Waggener and Heine are to prepare a resolution in defense of retaining the present status of professional boards.

It was recommended that the Council and its member associations build their support in behalf of the approved programs around the additional benefits to public health and safety to be derived therefrom. Copies of legislative material may be sent to the secretary of the Council for re-distribution or to member groups of the Council.

It was taken by consent that the Council hold one regular meeting each year and that special meetings be held on call by the chairman.

Miss Winkler moved that the secretary send a statement of 1953 dues to member associations. Mr. Carr seconded the motion which was approved. Annual dues are \$10.00 for each of the six member associations.

The following officers for 1953 were duly elected: Dr. E. E. Ewbank, chairman; Herbert H. Gerding, vice-chairman; Henry W. Heine, secretary-treasurer.

Dr. Jenkins then turned the gavel over to the newly elected chairman who responded with an appropriate message.

Upon motion by Dr. Rice, seconded by Dr. Mitchell, Council members expressed a rising vote

of thanks to Dr. Jenkins for his excellent service as chairman of the Council during the past eight years.

M. B. CATLETT, M.D., *Chairman*

DAVID A. DUKES, M.D.

GEORGE M. ELLIS, M.D.

MARION E. CLARK, M.D.

WARD LARAMORE, M.D.

INFANTILE PARALYSIS

No report.

COMMITTEE ON INSTRUCTIONAL COURSES

The Instructional Courses have become one of the most important features of the annual convention of the State Association and have been increasing in popularity with the years.

This success has been due to fine committee work and a splendid response on the part of the men who have taught these courses in the past.

An entirely new committee accepted the challenge of planning and giving the courses this year and maintaining the high standard of excellence which has characterized the courses of previous years.

A meeting was held in Indianapolis on May 3 at which six of the nine committee members were present. At this meeting the entire schedule for the courses was outlined; and most of the men who were to give the courses were named. Following this the committeemen made contact with these men and the program was quickly "wrapped up."

Such splendid and efficient work on the part of the members of this committee, and the fine response on the part of those who were asked to give the instruction were extremely gratifying.

The committee feels that it will have a program which will successfully maintain the worth and popular appeal of the Instructional Courses.

If doctors can work together as effectively in all their affairs as they did in this matter, their aims will never know defeat.

SETH W. ELLIS, M.D., *Chairman*

EDWIN A. LAWRENCE, M.D.

EUGENE L. BULSON, M.D.

M. B. GEVIRTZ, M.D.

STEPHEN L. JOHNSON, M.D.

JAMES M. BURK, M.D.

RUSSELL A. SAGE, M.D.

RAYMOND E. NELSON, M.D.

JOHN A. LARSON, M.D.

COMMITTEE ON MATERNAL AND CHILD HEALTH

As of August 1, 1953, your committee has had two meetings since its appointment, the first at Indianapolis on December 7, 1952, and the second in Brown County on May 24, 1953, with a meeting at the Abe Martin Lodge followed by an inspection at Nashville of the maternity service which is being conducted in that county. The organization and teaching of prenatal classes was discussed, the committee endorsed the idea that such classes be tried in different areas of the state, and requested that information about these classes be collected and made available by the Division of Maternal and Child Health of the State Board of Health, stipulating that referral by the doctor be made the basic requirement for admission to such classes. The committee also recommended that these classes be limited to pregnant women and young married women, and that such teaching not be extended to school-age girls. This was all done at the December meeting, and at that time, the committee recommended that a statement be placed in the Journals as to where and how care for medically indigent unwed mothers can be obtained. Since that time, the program which paid the medical and hospital expenses of unmarried mothers and the program which paid for hospital care at the Indiana University Medical Center of premature infants born at the Camp Atterbury Station Hospital have both been discontinued, effective June 30, 1953.

The committee felt it would be well for the Division of Maternal and Child Health to send out a brief on institutes on care of prematures, including a synopsis or sample program to the secretary of each local county medical society, hospitals, and full time health departments, these institutes being for nurses in obstetrics and pediatrics. This brief was intended to state that if there was enough local interest to warrant presenting such a program, the Division would be glad to furnish consultation service. Revision of the Brown County Maternity and Public Health Nursing Policies and Procedures was done by the committee and this work which was partly a hold-over from 1952 was finally completed and accepted as revised. The committee also recommended that a narrative story be written about the Brown County Maternity Service, including why it was established and how it functions, because of the uniqueness of the program and the interest it has aroused.

The committee recognized the need for a more concerted effort in the prevention of prematurity

and the care of premature infants, and it is on record more than once as favoring the establishment of a premature center in Indianapolis for teaching purposes. The committee recommended strongly that the Maternal and Child Health Division emphasize premature infant care in the institutes for nurses mentioned above.

Regional institutes on the care of premature infants were subsequently held in Richmond, New Albany, Indianapolis, and Hammond in cooperation with the Indiana League for Nursing, and another one was scheduled for Evansville. Material pertaining to the care of the premature infant is under preparation for the purpose of publishing it in a pamphlet form for general distribution under the combined sponsorship of this committee and the State Board of Health. A number of Gordon-Armstrong incubators have been placed in certain areas where they have been requested, and more remain to be placed.

The meeting held on May 24 in Brown County approved literature prepared for distribution to all hospitals in Indiana with departments of obstetrics, in care of the hospital superintendent, and to secretaries of local medical societies, on "Medical Care of Premature Infants", "Infant Formula Preparation at Home by Terminal Sterilization", "Instructions for Public Health Nurses", "Instructions to Parents". The Brown County Midwifery Service in Nashville was visited by the committee, and Mrs. Catherine Lory, nurse-midwife, explained the service and answered the committee's questions. The committee also had a conference with Drs. Schneider and Seibel in their office in Nashville. Further statistical studies are being made on the effectiveness and need for this work. The committee joined the two doctors in commending Mrs. Lory for the service that she has rendered Brown County.

Preliminary plans for a rheumatic fever pilot study for Columbus, Indiana were announced. This study is to be a joint project of the Heart Foundation, Division of Gerontology and Chronic Disease, and the Division of Maternal and Child Health, Indiana State Board of Health. It will be the first of several for Indiana and emphasis will be placed upon the prevention and diagnosis of rheumatic fever. The study will not include the treatment of rheumatic fever, as the patient will be returned to his family physician for therapy and care.

A. W. CAVINS, M.D., *Chairman*
REUBEN ALLEN CRAIG, M.D.
G. W. GUSTAFSON, M.D.
H. W. EGGERS, M.D.
MAHLON F. MILLER, M.D.
RUSSELL A. GARDNER, M.D.
J. L. STOELTING, M.D.
W. J. BROCKMAN, M.D.
C. CURTIS YOUNG, M.D.

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⁽¹⁾ Cheadle—Artificial Feeding and Food Disorders of Infants, Sixth Edition (1906)

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COMMITTEE ON MEDICAL CARE AND INSURANCE

The Committee on Medical Care and Insurance met for the first time in November of 1952 at which time a full representation of the committee was present and upon the invitation of the committee Mr. R. S. Saylor, executive vice-president of the Blue Shield Plan, was a guest.

Following orientation of the members of the committee by reading the minutes of the House of Delegates meeting on October 15, 1951 in which this committee was established and its duties were outlined, the committee asked Mr. Saylor to present suggestions for areas of study that might be undertaken by the committee.

The following was presented as suggestions for consideration by the committee:

1. Promote the idea advocated by the AMA of the physician discussing his fees with his patients.
2. Should Blue Shield insist on an itemized statement with a claim form?
3. Should Blue Shield offer an entire new certificate with a higher fee schedule in some areas?
4. Should Blue Shield experiment with broader studies of home and office calls?
5. Should Blue Shield conduct pilot studies of coverage of catastrophic illness and accidents using Blue Shield as a basic coverage—what form should this take?
6. How can the full support of the medical profession in the cooperation with the Blue Shield Plan be obtained?
7. The committee has undertaken an investigation into the types of insurance claim forms being used by the various companies in an effort to perhaps recommend the standardized forms for use by physicians with all companies.
8. In order to implement some of the decisions of the committee we have undertaken a survey of the profession in order to better prepare the committee for further study in some of these matters. Therefore the committee approves of the general policy of Blue Shield in adjusting their indemnities for certain new contracts which will more nearly approximate the average charge of a local community, such contracts to be on an indemnity basis. In order to gain some definite information on the fees charged in the various sections of the state the committee has undertaken to compile data on this subject by sending a questionnaire to each of the county societies. In this plan the committee will undertake a study of the fee schedules or the average fees charged for a representative list of services by the various

local medical societies of the association for statistical purposes, and the headquarters office was requested to aid in making this survey and study. It is the feeling of the committee that the results of this study will be useful to the profession as a whole, and also benefit the directors of the Indiana Blue Shield Plan in attempting to meet the demands of both the public and physicians for an indemnity schedule which will more nearly pay the cost of medical care.

By discussion of the points as outlined, the committee thought the majority of the items were within the scope of the responsibility of the committee. In view of this the committee went into detailed discussion of the various points and makes the following recommendations:

1. The committee urges that the association urge all members to adopt the idea advocated by the American Medical Association to discuss the fee the doctor is going to charge the patient before the services are rendered. Especially in relation to the indemnities to be paid by the prepaid medical plan.
2. It is the consensus of the committee that Blue Shield should be allowed to expand and to progress to meet the competition of the insurance carriers with respect to a higher indemnity schedule, home and office calls, and catastrophic coverage.
3. This committee urges that the House of Delegates approve and recommend that this committee and the Blue Shield board of directors conduct a continuing study and that positive steps be taken in effort to solve the problem of coverage for hospitalized medical emergencies such as diabetic and other comas; coronary occlusion; severe congestive failures; meningitis; internal hemorrhage and others.
5. The committee feels that the association should commend the directors of the Blue Shield Plan for their program of holding meetings of physicians and meeting with them individually and with their assistants to produce the desired result of better acquainting the profession with the Blue Shield Plan.

WM. C. REED, M.D., *Chairman*
D. D. STIVER, M.D.
H. R. STIMSON, M.D.
M. V. KAHLER, M.D.
FRANCIS B. MOUNTAIN, M.D.
F. S. NAPPER, M.D.
GEORGE WILLISON, M.D.
JOSEPH G. S. WEBER, M.D.
C. M. JONES, M.D.
RAYMOND C. BEELER, M.D.

COMMITTEE ON MENTAL HEALTH

No report.

COMMITTEE ON MILITARY MANPOWER

The past year has not been marked by any great change over the previous years in the number of doctors called to the Armed Services. Essentiality and availability determination of the local committees have been followed so far as has been possible under direction of the National Advisory Committee to Selective Service.

The protests of the mid-year meeting of the AMA and the efforts of the Armed Services Medical Department chiefs have lead to a reduction in the proportionate number of medical officers to troops. This change would seem to indicate that unless there is a marked decrease in the numbers in the Armed Forces there will be no change in the number of doctors required.

Another result of action at the mid-year meeting was a further revision of the physical standards. This has resulted in a re-evaluation of the physical status of a number of doctors in the lower priorities qualifying them for military service. While this action has not been entirely com-

pleted it has reduced the number of Priority III physicians called by Selective Service to this time.

The revision and extension of the Doctors Draft Law for two more years was activated July 1 and a careful resume of it has been published in the July issue of the state JOURNAL. It is hoped that the number of graduates of medical schools who are subject to regular Selective Service action will be sufficient to meet the need of the Armed Forces after 1955.

Several problems of physician distribution have arisen in the past year because of National Advisory Committee action preventing further deferment renewal for doctors in the lower priorities. This has worked especial hardship in those communities where all efforts were spent in attempting to obtain further deferments instead of in attracting new doctors.

Again the AMA Journal, the Indiana State Medical Journal and the ISMA Bulletin are keeping up to the minute information before you.

JOHN E. OWEN, M.D., *Chairman*

G. A. THOMAS, M.D.

JOHN M. PALM, M.D.

CARL G. MILLER, M.D.

GAYLE J. HUNT, M.D.

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COMMITTEE ON NECROLOGY

As usual this committee has prepared and furnished the Indiana State Medical Association Journal a complete record of names of those doctors who have died during the year, together with the causes of death and other statistical facts.

Other than this, this committee transacts no business.

JAMES B. MAPLE, M.D., *Chairman*

COMMITTEE ON PHYSICIAN-HOSPITAL RELATIONSHIP

The Physician-Hospital Relationship Committee was originally set up to carry out the recommendations of the Hess report. One section of this report states that the contracts of the Blue Shield will cover insurable medical services and Blue Cross will cover hospital services. Furthermore, since this report states that anesthesiology, pathology, radiology and physical medicine are as much an integral part of medicine as surgery, internal medicine or any other designated field of medicine these services should be included in the Blue Shield plan. The Indiana state societies of the anesthesiologists and radiologists have passed resolutions in favor of transferring their services from Blue Cross to Blue Shield. As yet this has not been carried out. Blue Cross had pledged at the time of its beginning that as soon as the Blue Shield plan was in operation medical services in anesthesiology, pathology and radiology would be transferred to Blue Shield. The Blue Shield plan, called the Mutual Medical Insurance Company, has been in operation for several years but the above services have not been transferred as promised. A workable plan for Indiana has not been developed. The only progress that has been made by the Mutual Medical Insurance Company of Indiana to transfer these services to the medical plan is the institution of a pilot plan in one company in Mishawaka which includes radiological services in the hospital and out-patient radiological services. This plan has been in operation for about one year and we have been informed that a progress report will be announced as soon as the figures are available for the full year. We hope that if this plan is successful in Mishawaka the Mutual Medical Insurance Company will try to sell a similar plan throughout the state.

This committee presented a resolution to the last House of Delegates meeting which was ap-

proved. Our resolution in regard to the magazine "Trustee" objected to the fact that this magazine publishes opinions on operation of the hospitals only from the administrator's viewpoint and it was suggested a liaison committee of the American Medical Association and American Hospital Association be set up to solve this problem. The resolution was presented at the American Medical Association meeting in June but was not approved as it was felt that there was much being done nationally along these lines and further efforts could best be done at state and local levels. We hope that this resolution has called attention to the national committees now active that the magazine "Trustee" has on numerous occasions had articles promoting the idea of a hospital becoming a medical center and suggesting that hospitals hire all physicians on a salary basis or charge high fees to belong to the hospital staff. Further efforts should be made to try to prevent hospitals from encroaching on the practice of medicine.

The chairman of this committee is automatically a member of a joint committee of physicians, hospital administrators and nurses on a state level. This joint committee is set up to improve the relations between these groups and to solve problems brought to its attention. The scope of this joint committee may well be enlarged so that physicians may have a more forceful voice in the activities of the hospitals. The physician can be most valuable in planning and instituting methods of improving patient care. The staffs of hospitals should be organized on a sound basis and insist on representation in the hospital organization in order to protect the physician's and patient's rights. The physician should be vitally interested and take active leadership. He should cooperate with the administrator, trustees and nurses in their common problems. It is too often true that the physicians, either by their own neglect or by being ignored by the trustees and administrators, have not been adequately recognized. We hope that better relations between physicians, administrators, trustees and nurses will be attained for better patient care in the hospitals. The Physician-Hospital Relations Committee can be of great service in the coming year if it becomes more active in this field of hospital and patient care and staff physician organization. This committee should continue to urge that Blue Shield plans be written to include the medical services not now covered in the present Blue Shield Plan.

KENNETH O. OLSON, M.D., *Chairman*

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COMMITTEE ON SCHOOL HEALTH AND PHYSICAL EDUCATION

The Committee on School Health and Physical Education had two meetings this year. The Committee felt that there should be some continuity in the personnel of the Committee on School Health and Physical Education and that if such continuity was deemed advisable by the State Medical Association, the following long range program is suggested:

The primary objective for the committee is to improve child health. The first step necessitates better liaison between school authorities, parents and local medical societies.

It is the consensus of opinion of the committee that our objectives could be met more effectively by attempting to reach those closely concerned with child health—school nurse, teacher, superintendent and parents, as well as the family doctor. It seemed more important to consider this direct approach rather than to concentrate on a state meeting at which only the "higher ups" could take part. The committee expressed a desire to continue the regional school health conferences initiated by the State Board of Health and State Medical Association to augment our "grass roots" approach.

The preparation of a pamphlet was suggested as a specific guide which would be acceptable to the school authorities and physicians. This guide should deal with specific problems with attempts at specific answers mutually acceptable by local medical societies and local school boards. It was thought that such a pamphlet could be used as a supplement to the present hygiene texts which are wholly inadequate.

In recognition of the fact that many of the textbooks used at the present time in the school system are antiquated, it was decided that the committee should investigate the present textbooks and to make specific recommendations as to changes which should be made in the teaching of health in the schools.

The committee decided to offer to the State Superintendent of Public Instruction, its services to aid in the selection of the health books used in the public schools in the state.

One of the more pressing problems in consideration of child health is a sound nutrition program. The growth and health of the child is dependent upon good nutrition. After the first year, guidance on nutritional matters is rarely in the hands of

the physician. The nutrition of the older child is left pretty much to chance. The committee hopes to make school health authorities as well as physicians, more aware of the importance of the problem of nutrition of the school child.

Other points considered by the committee were as follows:

1. To ask the AMA to give more modern information to authors of school textbooks and to ask the Academy of Pediatrics to aid in preparing textbook material.
2. To recommend that each county medical society have a school health committee which might have joint yearly meetings with school administration officials for discussion of pertinent local school health problems.
3. Recommend that physical exams be given every two or three years to school children and not just a preschool round-up. It was thought that whenever these examinations could be given by the physicians in their offices that this should be encouraged, and that those that were able to pay should give a small stipend on an individual parent-pupil basis.
4. The mimeograph forms used in these school physical examinations should be more sensible in their questionnaires and that this committee should develop a new standard simple form for such physicals.
5. The committee should disseminate information to county health nurses as well as school nurses.
6. Each school administration should be urged to carry liability insurance on its students who are engaging in athletic contests as well as accident insurance to care for students who are injured on the playgrounds or in the halls of the school.
7. The committee recommended that a physician should be on the program of the state teachers meeting each year.
8. The committee encouraged physicians to attend local P-TA meetings and if possible to appear on the program occasionally.

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JOHN E. FISHER, M.D.

COMMITTEE ON STATE FAIR

Your Committee on State Fair conducted the usual exhibit during the 1953 Indiana State Fair in the West Board of Health building. Occupying some 24 feet of wall space, the exhibit featured two new exhibits prepared for loan by the American Medical Association. One exhibit illustrated the percentage of the public's medical care dollar distributed to physicians, hospitals, nurses, dentists, pharmacists, and miscellaneous.

The other exhibit was a series of seven miniature displays depicting the seven points recommended by the AMA for better public relations. It explained the use of grievance committees, emergency call service, health examinations, insurance programs, etc.

Some 10,000 people lined up during the nine days of the fair to have their blood pressures taken at the booth by senior medical students.

The committee desires to express its appreciation to the women of the Indianapolis Auxiliary for their part in acting as hostesses at the booth and distributing pamphlets to those visiting the exhibit.

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COMMITTEE ON TRAFFIC SAFETY

The Committee on Traffic Safety has formulated a specific list of recommendations based on the overall observation of the existing safety program. We feel that the traffic safety program initiated by Governor Craig can be basically endorsed, as far as it goes. It seems that the following objectives could be urged as part of a long range program to insure greater safety on our streets and highways and reduce the enormous losses of life and property.

1. Strict enforcement of all traffic laws, especially those affecting moving traffic, at the local level. (Double and illegal parking and

bright lights to be classed with moving traffic offenses).

2. Educational. The driver convicted of moving traffic violations to have temporary suspension of driving privileges on first offense until he has satisfied a local traffic committee of the city, county or state police that he is thoroughly familiar with traffic rules and regulations. On a second conviction a like checkup with a physical checkup to determine physical fitness to operate a motor vehicle. Psychiatric examination could be requested if local traffic committee deemed it advisable. On third conviction driving privilege could be indefinitely revoked at discretion of local judge.
3. Really strict law enforcement concerning driving while under the influence of alcoholic beverages or drugs. Request for legislation permitting the judge discretionary power on conviction of above type cases to confiscate the vehicle and permanently revoke driving privileges. Vehicles so confiscated to be sold at auction and the proceeds to be used either for safety education programs or be turned over to local hospitals on an equitable basis to help defray the costs of emergency care of auto accident victims.
4. Intensive educational programs to promote courtesy among the motoring public, especially with monthly recognition of city, county and state courteous drivers and appropriate awards and recognition.
5. Continued study of highway engineering problems with the objective of making our highways as safe as possible from a structural and operational standpoint.
6. The committee would also recommend a study be made of the possibility of more rigid control of trucks similar to laws adopted by other states and a continuing study to find some means to keep bicycles and motor scooters off arterial highways.

O. E. WILSON, M.D., *Chairman*

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COMMITTEE ON TUBERCULOSIS

Your Committee met on Tuesday, April 28, 1953, at the Hotel Lincoln in Indianapolis, and submits the following report.

This Committee unanimously recommended that abnormal findings noted on miniature chest film surveys be reported to private physicians for follow-up. Routine chest X-rays of all admissions to general hospitals are urged. Likewise, all inmates of mental hospitals, penal institutions, nursing homes, county infirmaries, and food handlers should have routine chest films. Also we recommend that the present laws regarding chest films on all school personnel every three years should be more religiously carried out.

The Board of Health should call attention to the neglect in carrying out the law to school boards and township trustees. The Committee appealed to all practicing physicians to cooperate with the State Department of Health in the control of tuberculosis and that the laws regarding the commitment of recalcitrant tuberculosis patients be reprinted in our State Medical Journal. We further recommend that all patients discharged from tuberculosis hospitals should be reported to the physicians of their choice with a case summary and recommendations.

The Committee was in agreement that the following regulation is impracticable and should be left to the discretion of the attending physician concerning passes for patients: "Passes from the tuberculosis sanatoria or hospitals shall be restricted to individuals with a negative sputum; except that in extenuating circumstances, such as a death in the family, serious or critical illness in the family, an acute financial problem needing patient's presence to resolve or other emergency, the superintendent may authorize a pass for a positive sputum case.

"In the positive sputum cases, care shall be taken to assure that children under 15 years of age will not be in the home during the visit. The pass should be limited to overnight. Written permission from the local health officer shall be obtained by the patient for any pass extending beyond overnight. Under no circumstances shall the pass extend beyond 72 hours. Infectious cases may transfer from their hospital to their home only on written approval of the local health officer."

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COMMITTEE ON VENEREAL DISEASE

No formal meeting of the VD Committee of the State Association has been held during the year. The consensus of the members of the committee, recently polled, was that no meeting was necessary. Consequently, no report is being submitted.

GEORGE W. BOWMAN, M.D., *Chairman*

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THE JOURNAL

THE JOURNAL has prospered during the past twelve months, both financially and scientifically.

You are referred to the report of the Executive Committee for details regarding advertising revenue, printing costs, and special issues.

THE JOURNAL has been fortunate in having received a suitable number of scientific articles. These have been reviewed and studied by members of the Editorial Board. Revisions and rewriting have been recommended and accomplished where indicated. We have been able to accept enough material to maintain an adequate backlog of scientific papers. The present supply is large enough to allow sufficient time for preparation, and small enough to avoid undue delay in publication.

Plans for the further modernization of the format of THE JOURNAL are continuing. The use of a large type face and the use of new heads for articles was accomplished last year. Further improvement of the makeup of the entire journal, including a new cover design, to conform to the improvements already made, will be forthcoming soon.

"Opinions From Here and There," a legislative news insert prepared by the Committee on Public Policy and Legislation, was well received on its initial trial and has been continued.

Editorial clippings for the feature "The Fourth Estate Looks at Medicine" have been sufficient in number, but have not provided coverage for the entire state. All members of the Association are urged to submit editorial clippings from their home or other newspapers, in order to afford as comprehensive a coverage as possible.

Special acknowledgment is due the officers and members of the Section on General Practice for their enthusiastic and able participation in preparation of the August, 1953 General Practice Issue.

In conclusion the editor wishes to pay tribute to the devotion and hard work in the interest of THE JOURNAL of the Associate Editors, the members of the Editorial Board, and Mr. James Waggener, Mrs. Jeanne Grover, and Miss Persis MacDonald.

FRANK B. RAMSEY, *Editor*

LIAISON COMMITTEE WITH THE INDIANA ASSOCIATION OF LICENSED NURSING HOMES

Dr. James W. Denny and Mr. Waggener, executive secretary, met with representatives of the Indiana Association of Licensed Nursing Homes, the Indiana State Nurses Association, the Indiana State Hospital Association, the State Board of Health, and the Indiana Department of Public Welfare, in Parlor D of the Claypool Hotel, Indianapolis, on Wednesday, June 24, 1953, at 2:00 p.m. This was in response to the invitation recently received by the Indiana State Medical Association requesting the appointment of a liaison committee for the purpose of assisting the Indiana Association of Licensed Nursing Homes in the establishment of operating policies and guides for the nursing homes of Indiana.

The meeting was opened by Mr. Harry Latham, attorney for the Nursing Home Association, who outlined the goals of the Association, following the review of the history of the organization.

Mr. Latham stated the Nursing Homes Association had come into being after a need was felt for raising the standards and reputation of the nursing homes in operation in the state. As a result, many of these banded together to form the association and had worked closely with the Department of Public Welfare and Health to procure legislation which would serve to raise the standards of the nursing homes, and serve to remove some of the questionable homes then in operation. This was accomplished by passage of legislation requiring licensure and inspection of nursing homes by the Department of Public Welfare.

Mr. Latham pointed out it was now the hope of the Association, that through this liaison committee their group would be in a position to further raise their standards and proposed the following:

1. Need increased standards which they hope will become a part of the licensure law.
2. Require that a registered nurse be on duty at all times.
3. That nursing care be under supervision of registered nurse.
4. That nursing homes be recognized under Blue Cross and other hospital insurance plans for convalescent care of hospital patients.

In explaining point four it was pointed out the nursing home group felt they had a place in the care of convalescent patients, who could be referred to the home by the hospital or the physician for this service. This would serve to provide more hospital beds for emergency cases. To do this, they felt it necessary that everything be done by the group to bring their standards and require-

ments to such a high degree that they could be recognized as an integral part of the health care plan of the state.

Mr. Eastburg, president of the nursing home group, then called on representatives of the organizations present, all of whom expressed willingness to be of whatever assistance they could in helping the group in their problems.

Mr. Eastburg asked Doctor Denny if the medical profession would be willing to set up an inspection committee to inspect the nursing homes.

Doctor Denny stated that while he was in no position to give a definite commitment on the part of the Indiana State Medical Association on any matter, he was of the opinion that the medical group would not enter into any agreement for the establishment of an inspection committee. Doctor Denny pointed out that he was sure the Association was of the impression that the group requested the medical group to appoint a committee for the purpose of counseling and advising the Nursing Home Association on medical problems which might confront the group. This committee has been established and I am sure we would be willing to work in this manner, but I am certain that we would not undertake an inspection of nursing homes.

Further clarification was requested by Doctor Denny of the purpose of the meeting and specifically what was meant by an inspection by medical doctors as he was under the impression the Indiana Department of Public Welfare and the Indiana State Board of Health were legally constituted as the official state licensing and inspection agencies for the nursing homes.

Mr. Eastburg and Mr. Latham explained that perhaps their choice of words was incorrect, but what they meant was that the medical profession could establish a committee for the purpose of clearing complaints regarding nursing homes and through this method could forward these to the nursing home association; the same could be used as an educational system for improvement of nursing homes. Also that the medical group might be willing to initiate suggestions for improvement of the homes.

Doctor Denny called attention to the fact that the Indiana State Medical Association had a committee specifically charged with the responsibility for adjudicating complaints, and if complaints were received he felt certain this established committee would handle them. He pointed out that to his knowledge no complaints had been received in which a nursing home was involved, and likely would not, unless made by a physician. It was pointed out that complaints from the public on nursing homes would not likely be received by the Medical Association.

Doctor Denny commented further on the proposals of the group by complimenting them on

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their effort to raise the quality of nursing home care, and expressed the congratulations of the medical profession for the hard work that had evidently been done by the leaders in their group to remove the stigma that had developed through some of the previous nursing homes and the operators.

He cautioned the group, however, that they should go slow in legislating too many requirements and standards, or they would defeat the very purpose of the nursing home, and make them so expensive they could not be used.

The following points were listed by him in his suggestions to the group:

1. The nursing home was established or came into being through the need that existed for some place to care for the aged, who were unfortunate enough not to have someone to care for them or whose relatives refused to care for them in a private home.
2. The requirement that every nursing home have a registered nurse on duty at all times, and that she be in charge of the supervision of care, was in his opinion unnecessary and undesirable at this time because:
 - a. This would tend to make the care more expensive.
 - b. There was an acute shortage of nurses,



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so acute in fact that hospitals were having a hard time keeping the staffs complete.

- c. If you did make this a requirement, it would mean that nursing homes would be forced to bid against hospitals, industry and physicians, for nursing services, thus making it a very expensive matter.
3. Good licensed practical nurses can do the job, providing the individual home has good medical advice.
4. Too high standards would be troublesome and expensive.
5. If homes are to care for convalescing patients, patients should be referred there by the physician and not the hospital.
6. While there is a possibility of nursing homes being acceptable for care of convalescing patients, thus relieving the hospitals, the homes should not attempt to place themselves as equal to hospitals or in the position of competing with hospitals, as this would only serve to raise the cost of care to such a degree as to make the use of the homes, as they are now being used, prohibitive in cost.
7. The medical profession is willing to be of assistance in helping you solve your medical problems, and I am sure that we can say at this time that we are willing to act in an advisory capacity to your association if that is your desire.

Following discussion by representatives of other groups the meeting was adjourned.

I hope that I, as your representative, have been proper in the statements I have made to this group, and that they reflect the thinking of the Indiana State Medical Association. It was rather difficult to attend this meeting without having advance knowledge as to just what was to transpire so that I might have been better prepared to discuss the subject at hand. It was apparent that representatives of the nursing home group were not too sure themselves on just how this liaison group was to function, or as to the purposes for the meeting. There was some hesitation on their part and it seemed apparent that they, too, were not too sure as to just what they wanted.

I would report that I think this first meeting was successful as it provided for an exchange of ideas among the groups represented. I feel that we should continue to offer our assistance to this organization so some good can come from this association for the purpose of improving the health care and services that are available to the people of Indiana.

JAMES W. DENNY, M.D., *Chairman*
CLEON A. NAFE, M.D.
J. WILLIAM WRIGHT, SR., M.D.

LIAISON COMMITTEE WITH INDIANA DEPARTMENT OF PUBLIC WELFARE

The committee appointed by Doctor Crimm, in accordance with a resolution passed by the House of Delegates in April 1953, to meet with the State Department of Public Welfare, held such a meeting June 3, 1953. Members present were Dr. Richard P. Good, and Dr. Russell J. Spivey. Drs. E. S. Jones, Hammond, and E. L. Fitzsimmons, Evansville, were absent because of attending the A.M.A. Convention.

A committee meeting was also held on August 12, with all members present in the headquarters of the Indiana State Medical Association. The following report was adopted at this meeting.

At the meeting of this committee with the State Department of Public Welfare, the resolution as passed by the House of Delegates was read. The prime object of the resolution was to study the possibility of obtaining a uniform fee schedule throughout the state for medical care of welfare recipients.

The entire Medical Care Program was discussed and the Welfare Act was interpreted by the Deputy Attorney General, Mr. Crawford. The law requires that medical fees be negotiated in each county by the county board and the local physicians, then forwarded to the State Welfare Board for approval. The board has a policy of approving fee schedules that are not more than fees ordinarily charged in the same county for like services to private patients. The welfare director stated that he could not disapprove of too low a fee scale without dictating to the local boards which is in violation of the law.

The State Department was in sympathy with our aim of a more standard fee scale as it would simplify the administration of the local departments in their office and be more equitable to the physicians in the state. The fees varied considerably throughout the state. Many counties had adopted the Blue Cross, Blue Shield scale and others, the Veterans' Administration scale, while others were as low as 50% of the ordinary fee in the counties.

Therefore, the establishment of a uniform state fee schedule for medical services is impossible under the present Welfare Act.

The committee also studied the request of the Welfare Department for a liaison committee from

the Indiana State Medical Association. This request has been presented to the House of Delegates by the council. We recommend that this committee be established not only to function as a liaison, but also to assist the local county society in obtaining a better understanding with the local Welfare Board.

RICHARD P. GOOD, M.D., *Chairman*

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*Clint C. Sourwine, M.D.
Robert K. Webster, M.D.

CLINTON COUNTY

N. B. Combs, M.D.
Milton W. Erdel, M.D.
George K. Hammersley, M.D.
C. D. Holmes, M.D.
Harry T. Stout, M.D.

DAVIESS-MARTIN COUNTIES

A. G. Blazey, M.D.
Hamlin B. Lindsay, M.D.
Horace O. Norton, M.D.
Robert H. Rang, M.D.
James R. Rohrer, M.D.
William C. Schafer, M.D.

DEARBORN-OHIO COUNTIES

Leslie M. Baker, M.D.
J. C. Elliott, M.D.
G. S. Fessler, M.D.
Fred D. Houston, M.D.
J. K. Jackson, M.D.
Charles N. Manley, M.D.
J. M. Pfeifer, M.D.
Omer H. Stewart, M.D.
George A. Vail, M.D.

DECATUR COUNTY

Robert P. Acher, M.D.
D. D. Dickson, M.D.
J. T. Morrison, M.D.

DEKALB COUNTY

Floyd B. Coleman, M.D.
Harry M. Covell, M.D.
Clayton B. Hathaway, M.D.
Archie V. Hines, M.D.
Harland V. Hippensteel, M.D.
Loren E. Jinnings, M.D.
Floyd B. Kantzer, M.D.
D. Monroe Reynolds, M.D.
Russell P. Reynolds, M.D.
Charles I. Weirich, M.D.

DELAWARE-BLACKFORD COUNTIES

William B. Adams, M.D.
Charles R. Alvey, M. D.
Clay A. Ball, M.D.
Henry E. Bibler, M.D.
Thomas Botkin, M.D.
Leland G. Brown, M.D.
Stewart D. Brown, M.D.
Thomas M. Brown, M.D.
Paul E. Burns, M.D.
R. M. Butterfield, M.D.
E. H. Clauser, M.D.
J. H. Clevenger, M.D.
George H. Dando, M.D.
William Deutsch, M.D.
Lavern C. Garling, M.D.
Marvin F. Greiber, M.D.
T. R. Hayes, M.D.
R. L. High, M.D.
Irwin S. Hostetter, M.D.
J. R. Hurley, M.D.
Grace C. Kammer, M.D.
James A. McClintock, M.D.
F. W. McDowell, M.D.
R. M. McMichael, M.D.
Lall G. Montgomery, M.D.
T. R. Owens, M.D.
William J. Quick, M.D.
Glynn A. Rivers, M.D.
M. G. Schulhof, M.D.
John R. Stanley, M.D.
Edward F. Tindal, M.D.
Hugh M. Tomlin, M.D.
Edward F. Wierzalls, M.D.
Amelia T. Wood, M.D.

DUBOIS COUNTY

Sohrab Amini, M.D.
Charles H. Klammer, M.D.
Fielding P. Williams, M.D.

ELKHART COUNTY

Charles L. Amick, M.D.
H. Clair Amstutz, M.D.
Theodore D. Arlook, M.D.
Robert L. Bender, M.D.
Frederick W. Bigler, M.D.
Elmer R. Billings, M.D.
George R. Bloom, M.D.
R. S. Bolin, M.D.
George E. Bowdoin, M.D.
Walter Ames Compton, M.D.
I. L. Eby, M.D.
L. A. Elliott, M.D.
Thomas A. Elliott, M.D.
Floyd M. Freeman, M.D.
Jack W. Hannah, M.D.
C. M. Hostetler, M.D.
Arthur W. Hull, M.D.
Burton Kintner, M.D.
Kenneth E. Leasure, M.D.
Richard Logan, M.D.
F. S. Martin, M.D.
Galen R. Miller, M.D.
Hugh A. Miller, M.D.
S. T. Miller, M.D.
Edward P. Minsinger, M.D.
E. G. Neidballa, M.D.
William Paff, M.D.
George E. Paine, M.D.
Vernon K. Pancost, M.D.
G. B. Patrick, M.D.
Lloyd O. Rupe, M.D.
L. H. Simmons, M.D.
Jancey S. Slabaugh, M.D.
William M. Stubbins, M.D.
Leonard F. Swihart, M.D.
John P. Turner, M.D.
A. C. Yoder, M.D.
C. Richard Yoder, M.D.
R. H. Young, M.D.

* Deceased

* As of August 20, 1953.

**FAYETTE-FRANKLIN
COUNTIES**

M. H. Dale, M.D.
Edward H. Daley, M.D.
George M. Ellis, M.D.
Rodney B. Fruth, M.D.
Virgil J. Fruth, M.D.
Albert F. Gregg, M.D.
J. M. Lockhart, M.D.
Frank H. Neukamp, M.D.
Elmer E. Peters, M.D.

FLOYD COUNTY

Howard W. Byrn, M.D.
William H. Garner, M.D.
John M. Paris, M.D.
G. I. Polhemus, M.D.
Harry E. Voyles, M.D.
Nelson A. Wolfe, M.D.

**FOUNTAIN-WARREN
COUNTIES**

James W. Crain, M.D.
Gilbert Himebaugh, M.D.
Fred H. Priebe, M.D.
Hubert M. Rusk, M.D.
Byron J. Smith, M.D.
Lowell R. Stephens, M.D.

FULTON COUNTY

J. C. Glackman, Sr., M.D.
C. L. Richardson, M.D.
A. E. Stinson, M.D.

GIBSON COUNTY

John K. Folek, M.D.
Raymond G. Geick, M.D.
Samuel Geller, M.D.
Virgil McCarty, M.D.
A. F. Marchand, M.D.
E. V. Marchand, M.D.
Harold G. Petitjean, M.D.
Amos H. Rhodes, M.D.

GRANT COUNTY

Charles F. Abell, M.D.
Robert W. Currie, M.D.
Joseph B. Davis, M.D.
Richard M. Davis, M.D.
Leo L. Diamond, M.D.
Henry Fisher, M.D.
Max Ganz, M.D.
M. Arthur Grant, M.D.
Max R. Long, M.D.
Eleanor McIlwain, M.D.
H. Allison Miller, M.D.
James P. Powell, M.D.
J. G. Rhorer, M.D.
F. H. Simmons, M.D.
Claude E. Skomp, M.D.
Eugene H. Wicker, M.D.
John W. Woodbury, M.D.

GREENE COUNTY

A. H. Fender, M.D.
J. A. Graf, M.D.
George C. Porter, M.D.

HAMILTON COUNTY

Claude M. Donahue, M.D.
Robert F. Harris, M.D.
John S. Hash, M.D.
Oscar D. Havens, M.D.
Eugene Newby, M.D.
Ray Shanks, M.D.
Harold W. Shonk, M.D.

HANCOCK COUNTY

Wayne H. Endicott, M.D.
R. E. Kinneman, M.D.
Robert W. Kuhn, M.D.
Harold M. Manifold, M.D.
Hugh K. Navin, M.D.

**HARRISON-CRAWFORD
COUNTIES**

W. E. Amy, M.D.
Louis H. Blessinger, M.D.
Carl E. Dillman, M.D.
O. R. Lynch, M.D.

HENDRICKS COUNTY

Paul W. Elliott, M.D.
M. O. Scamahorn, M.D.
O. T. Scamahorn, M.D.

HENRY COUNTY

John E. Fisher, M.D.
William C. Heilman, M.D.
G. E. Iterman, M.D.
Walter U. Kennedy, M.D.
Frank C. McDonald, M.D.
William S. Robertson, M.D.
George E. Stauffer, M.D.

HOWARD COUNTY

Elton R. Clarke, M.D.
Reuben Craig, M.D.
P. W. Ferry, M.D.
Marvin N. Golper, M.D.
Richard P. Good, M.D.
W. H. Hutto, M.D.
B. D. Lung, M.D.
Guy Morford, M.D.
Durward W. Paris, M.D.
Max Rudicel, M.D.
Frederick C. Schwartz, M.D.
H. B. Shoup, M.D.

HUNTINGTON COUNTY

C. S. Black, M.D.
H. S. Brubaker, M.D.
M. G. Erehart, M.D.
Howard H. Marks, M.D.
H. C. Woods, M.D.

JACKSON COUNTY

Joseph M. Black, M.D.
Louis H. Osterman, M.D.
J. E. Shields, M.D.
Wilbur H. Shortridge, M.D.

JASPER-NEWTON COUNTIES

Ernest R. Beaver, M.D.
W. C. Mathews, M.D.
Martin J. O'Neill, M.D.
W. G. Pippenger, M.D.
Richard Schantz, M.D.
*F. G. Sink, M.D.
Marsh Hunter Smith, M.D.
Roscoe S. Yeagerlehner, M.D.

JAY COUNTY

John M. Engle, M.D.
J. S. Fitzpatrick, M.D.
E. H. Hall, M.D.
Forrest E. Keeling, M.D.
John Lansford, M.D.
Donald E. Spahr, M.D.
R. M. Steffy, M.D.

**JEFFERSON-SWITZERLAND
COUNTIES**

A. G. W. Childs, M.D.
W. E. Childs, M.D.
Lewis E. Jolly, M.D.
George A. May, M.D.
J. W. Modisett, M.D.
Marcella Modisett, M.D.
William A. Shuck, M.D.
Anna Goss Turner, M.D.
Oscar A. Turner, M.D.
S. A. Whitsitt, M.D.
R. O. Zink, M.D.

JENNINGS COUNTY

Dennis W. Matthews, M.D.

JOHNSON COUNTY

Helen B. Barnes, M.D.
J. H. Machledt, M.D.
Donald C. Manuel, M.D.
W. L. Portteus, M.D.
O. A. Province, M.D.
W. D. Province, M.D.
K. I. Sheek, M.D.
George A. Tiley, M.D.
*Russell C. Wilson, M.D.
C. E. Woodcock, M.D.

KNOX COUNTY

Richard M. Anderson, M.D.
Herbert O. Chattin, M.D.
E. T. Edwards, M.D.
Maurice S. Fox, M.D.
Carl L. Green, M.D.
Virgil C. McMahan, M.D.
D. H. Richards, M.D.
William Schulze, M.D.
John A. Scudder, M.D.
K. L. Shaffer, M.D.
Samuel J. Smith, M.D.
Frederic Spencer, M.D.
Adron A. Sullenger, M.D.
Norbert Welch, M.D.

KOSCIUSKO COUNTY

George M. Haymond, M.D.
Everett W. Thomas, M.D.
Dan L. Urschel, M.D.

LAGRANGE COUNTY

K. M. Lehman, M.D.

LAKE COUNTY

Herbert I. Arbeiter, M.D.
C. A. Beilke, M.D.
Carl H. Bender, M.D.
R. N. Bills, M.D.
Samuel G. Brady, M.D.
Harry Brandman, M.D.
Abraham A. Brauer, M.D.
L. R. Brown, M.D.
E. H. Carleton, M.D.
Raymond Carmody, M.D.
J. J. Chevigny, M.D.
Leo K. Cooper, M.D.
Alfred J. Dainko, M.D.
J. R. Doty, M.D.
Lowell E. Dupes, M.D.
H. M. English, M.D.
John Ferry, M.D.
Isadore E. Friedman, M.D.
H. Glenn Gardiner, M.D.
M. B. Gevirtz, M.D.
Joseph Goldstone, M.D.
W. G. Grosso, M.D.
Norman B. Hasler, M.D.
Zigfield Hodurski, M.D.
William H. Howard, M.D.
Clifford M. Jones, M.D.
E. S. Jones, M.D.
R. W. King, M.D.
Julius M. Klaus, M.D.
Meyer W. Kobrin, M.D.
John E. Komoroske, M.D.
Hedwig S. Kuhn, M.D.
Forrest R. LaFollette, M.D.
J. F. Larrabee, M.D.
Herbert A. Lautz, M.D.
Henry S. Lebioda, M.D.
T. B. Lorenty, M.D.
Desmond F. McGuire, M.D.
Joseph Markle, M.D.
O. L. Marks, M.D.
R. Milton May, M.D.
E. Gregory Moore, M.D.
H. R. Morris, M.D.
J. F. Murphy, M.D.
James Nakadate, M.D.
J. P. Ornelas, M.D.
R. H. Palmer, M.D.
Geraldine M. Peiffer, M.D.
*Samuel J. Petronella, M.D.
Jean Pilot, M.D.
Franklin F. Premuda, M.D.
D. T. Rendel, M.D.
A. W. Rhind, M.D.
P. G. Row, M.D.
D. H. Rudser, M.D.
Jacob Sagel, M.D.
Jacob Schlessinger, M.D.
Thomas J. Senese, M.D.
A. G. Seyler, M.D.
Michael Shellhouse, M.D.
George Slama, M.D.
H. R. Stimson, M.D.
Joseph A. Teegarden, Jr., M.D.
Joseph A. Teegarden, Sr., M.D.
Daniel D. Thomas, M.D.
L. L. Teplinsky, M.D.
William R. Troutwine, M.D.
Jack M. Troy, M.D.
Thomas C. Tyrrell, M.D.
H. A. Vore, M.D.
J. P. Vye, M.D.
Adolph P. Walker, M.D.
Frederic H. Wood, M.D.
Robert L. Young, M.D.

LAPORTE COUNTY

M. L. Bankoff, M.D.
Harry L. Brooks, M.D.
Fred S. Carter, M.D.
J. D. Cartwright, M.D.
John B. Cleveland, M.D.
Clem H. Elshout, M.D.
David J. Evans, M.D.
F. M. Fargher, M.D.
Donald J. Feerer, M.D.
Carlton N. Fischer, M.D.
R. J. Frost, M.D.
M. D. Gardner, M.D.
M. J. Hetman, M.D.
Charles Hillenbrand, M.D.
R. B. Jones, M.D.
Robert M. Kelsey, M.D.

* Deceased

John T. Kemp, M.D.
Victor F. Kling, M.D.
Benjamin M. Kohrman, M.D.
G. O. Larson, M.D.
E. E. Linn, M.D.
W. B. Martin, M.D.
M. G. Meyer, M.D.
Louis Moosey, M.D.
Samuel P. Morgan, M.D.
C. E. Muhleman, M.D.
D. D. Oak, Sr., M.D.
L. F. Piazza, M.D.
C. R. Plank, M.D.
John C. Richter, M.D.
Wilbur W. Ross, M.D.
John S. Scott, M.D.
A. R. Simon, M.D.
George VonAsch, M.D.
Adolph Weinstock, M.D.
Robert F. Wilcox, M.D.

LAWRENCE COUNTY

L. E. Benham, M.D.
J. C. Dusard, M.D.
K. T. Edmonds, M.D.
Charles B. Emery, M.D.
J. R. Hamilton, M.D.
O. L. Meyer, M.D.
*Harry C. Ragsdale, M.D.
J. P. Scherschel, M.D.
R. B. Smallwood, M.D.
William B. Strickland, M.D.

MADISON COUNTY

Robert L. Armington, M.D.
M. A. Austin, M.D.
Donald P. Bixler, M.D.
M. C. Drake, M.D.
Benton M. Hensler, M.D.
J. L. Lamey, M.D.
J. L. Larmore, M.D.
W. A. Laudeman, M.D.
S. W. Litzenberger, M.D.
P. L. Long, M.D.
Roy W. Maxon, M.D.
Calvin P. McLaughlin, M.D.
George H. Overpeck, M.D.
R. R. Ploughe, M.D.
Roger R. Reed, M.D.
C. V. Rozelle, M.D.
Wallace A. Scea, M.D.
J. H. Stamper, M.D.
Gordon B. Wilder, M.D.

MARION COUNTY

Anonymous
J. L. Arbogast, M.D.
Robert D. Arnold, M.D.
Otto H. Bakemeier, M.D.
J. S. Battersby, M.D.
H. W. Beaver, M.D.
E. M. Beck, M.D.
John W. Beeler, M.D.
Raymond Beeler, M.D.
Morley Berger, M.D.
Warren L. Bergwall, M.D.
Jacob K. Berman, M.D.
George Bernstein, M.D.
Lester D. Bibler, M.D.
C. R. Bird, M.D.
Edward F. Bloemker, M.D.
Don G. Bock, M.D.
F. A. Boyer, M.D.
Boynton H. Booth, M.D.
John R. Brayton, M.D.
William L. Bridges, M.D.
Archie E. Brown, M.D.
DeWitt W. Brown, M.D.
Frances T. Brown, M.D.
W. L. Bruetsch, M.D.
Harold F. Burdette, M.D.
Rolla D. Burghard, M.D.
L. E. Burney, M.D.
Hugo M. Cahn, M.D.
Herbert F. Call, M.D.
John A. Campbell, M.D.
*C. J. Clark, M.D.
Cecil P. Clark, M.D.
L. J. Clark, M.D.
James N. Collins, M.D.
Chester C. Conway, M.D.
Matthew Cornacchione, M.D.
James V. Cortese, M.D.
Thomas A. Cortese, M.D.
Kenneth L. Craft, M.D.
Howard T. Craven, M.D.
P. K. Cullen, M.D.
Dale Davidson, M.D.
Forrest L. Denny, M.D.
J. W. Denny, M.D.
Paul A. DesJean, M.D.

* Deceased

Byron Dill, M.D.
A. M. Donato, M.D.
Hal Doran, M.D.
William M. Dugan, M.D.
Edwin W. Dyar, M.D.
Joseph R. Eastman, Jr., M.D.
J. Wayne Ebert, M.D.
B. E. Ellis, M.D.
Ralph Everly, M.D.
Robert B. Failey, Jr., M.D.
C. B. Fausset, M.D.
W. J. Fitzgerald, M.D.
Joseph O. Flora, M.D.
William L. Franklin, M.D.
Bernard Frazin, M.D.
Warren S. Freeborn, M.D.
Elmer Funkhouser, M.D.
E. T. Gaddy, M.D.
William D. Gambill, M.D.
Robert L. Gammieri, M.D.
George J. Garceau, M.D.
Sprague H. Gardiner, M.D.
Buckman Gardner, M.D.
W. Stanley Garner, M.D.
R. A. Garrett, M.D.
W. D. Gatch, M.D.
Roy A. Geider, M.D.
Fred E. Gifford, M.D.
Charles F. Gillespie, M.D.
J. L. Glendening, M.D.
Morgan E. Greene, M.D.
Charles F. Gregory, M.D.
John H. Greist, M.D.
T. L. Grisell, M.D.
G. W. Gustafson, M.D.
H. G. Hamer, M.D.
R. M. Hansell, M.D.
Carroll W. Hasewinkel, M.D.
J. L. Haymond, M.D.
Philip William Hedrick, M.D.
John W. Hendricks, M.D.
John E. Heubi, M.D.
Fletcher Hodges, M.D.
J. William Hofmann, M.D.
J. E. Holman, Sr., M.D.
R. D. Howell, M.D.
Lester H. Hoyt, M.D.
H. L. Hummons, M.D.
Frank L. Jennings, M.D.
T. W. Johnson, M.D.
Allen W. Jones, M.D.
Francis P. Jones, M.D.
Rex M. Joseph, M.D.
M. V. Kahler, M.D.
W. F. Kelly, M.D.
Y. D. Kim, M.D.
John K. Kingsbury, M.D.
R. J. W. Kinzel, M.D.
Harry E. Kitterman, M.D.
Robert E. Knight, M.D.
Karl C. Kohlstaedt, M.D.
Karl Koons, M.D.
C. B. LaDine, M.D.
Emmett B. Lamb, M.D.
Leroy Lavine, M.D.
J. M. Leffel, Jr., M.D.
Henry S. Leonard, M.D.
Melvin Lichtenberg, M.D.
P. G. Lindenberg, M.D.
Oscar Ludwig, M.D.
W. B. Lybrook, M.D.
J. M. McIntyre, M.D.
C. H. McCaskey, M.D.
A. David McKinley, M.D.
Ralph J. McQuiston, M.D.
C. R. Marshall, M.D.
Robert J. Marvel, M.D.
W. B. Matthews, M.D.
B. J. Matthews, M.D.
W. M. Matthews, M.D.
Lyman Meiks, M.D.
Earl W. Mericle, M.D.
Paul Merrell, M.D.
H. N. Middleton, M.D.
Joseph A. Miller, M.D.
W. J. Millikan, M.D.
W. P. Moenning, M.D.
George J. Morec, M.D.
Lewis E. Morrison, M.D.
Herschel C. Moss, M.D.
Lillian B. Mueller, M.D.
Paul F. Muller, M.D.
E. B. Mumford, M.D.
Roy V. Myers, M.D.
Cleon A. Nafe, M.D.
Louis T. Need, M.D.
Philip Nohe, M.D.
Earl J. O'Brien, M.D.
Harold C. Ochsner, M.D.
Otis N. Olvey, M.D.
Claude F. Otten, M.D.
John E. Owen, M.D.

Byron J. Parks, M.D.
Edward J. Pauley, M.D.
M. B. Paynter, M.D.
T. V. Petranoff, M.D.
Robert D. Pickett, M.D.
Arvine G. Popplewell, M.D.
Francis W. Price, M.D.
W. F. Ramage, M.D.
Frank B. Ramsey, M.D.
Philip B. Reed, M.D.
Simon Reisler, M.D.
Raymond M. Rice, M.D.
J. W. Ricketts, M.D.
Alton H. Ridgway, M.D.
J. O. Ritchey, M.D.
Donald L. Rogers, M.D.
Robert J. Rohn, M.D.
Floyd T. Romberger, Jr., M.D.
Irving Rosenbaum, Jr., M.D.
A. T. Ross, M.D.
K. R. Ruddell, M.D.
Stephen J. Rudolph, M.D.
B. K. Rust, M.D.
Glen V. Ryan, M.D.
Harry J. Sacks, M.D.
T. F. Schlaegal, Jr., M.D.
Gabriel Schuchman, M.D.
Wendell A. Shullenberger, M.D.
Dwight W. Shuster, M.D.
Robert P. Scott, M.D.
Herbert Sedam, M.D.
M. R. Shafer, M.D.
W. A. Shullenberger, M.D.
Harris B. Shumacker, Jr., M.D.
H. W. Sigmond, M.D.
J. L. Sims, M.D.
David Joe Smith, M.D.
Francis C. Smith, M.D.
Lester A. Smith, M.D.
R. A. Solomon, M.D.
J. F. Spahr, Jr., M.D.
Carl B. Sputh, Jr., M.D.
Carl B. Sputh, Sr., M.D.
Thomas A. Stump, M.D.
Alfred B. Swanson, M.D.
Alfred T. Symmes, M.D.
Dan E. Talbott, M.D.
Clifford C. Taylor, M.D.
Frederic W. Taylor, M.D.
Charles E. Test, M.D.
E. P. Tischer, M.D.
Harold M. Trusler, M.D.
Warren S. Tucker, M.D.
Harlan H. Tyner, M.D.
M. J. VanDorn, M.D.
Frank C. Walker, M.D.
F. C. Warfel, M.D.
Lorance White, M.D.
Irvin W. Wilkens, M.D.
C. D. Williams, M.D.
Ralph C. Wilmore, M.D.
Douglas E. Wilson, M.D.
William Niles Wishard, Jr., M.D.
Don E. Wood, M.D.
Richard H. Worley, M.D.
J. William Wright, M.D.
James W. Young, M.D.
Woodson C. Young, M.D.
Phyllis K. Zerfas, M.D.

MARSHALL COUNTY

C. R. Burket, M.D.
R. K. Pomeroy, M.D.
Thomas G. Sheller, M.D.
A. A. Thompson, M.D.
L. W. Vore, M.D.
R. L. Witham, M.D.

MIAMI COUNTY

E. Lee Burrous, M.D.
C. R. Herd, M.D.
Stephen D. Malouf, M.D.
H. E. Rendel, M.D.

MONTGOMERY COUNTY

S. J. Alexander, M.D.
T. Z. Ball, M.D.
Fred M. Blix, M.D.
Jess E. Burks, M.D.
Fred N. Daugherty, M.D.
William H. Davis, M.D.
Frank Denny, M.D.
Wemple Dodds, M.D.
T. C. Haller, M.D.
Claude A. Hendrix, Jr., M.D.
J. W. Humphreys, M.D.
F. Dale Johnson, M.D.
H. D. Kindell, M.D.
H. A. Kinneman, M.D.
James M. Kirtley, M.D.
Byron N. Lingeman, M.D.

William M. Mount, M.D.
 Carl B. Parker, M.D.
 Norman F. Peacock, M.D.
 Robert H. Pierson, M.D.
 J. L. Sharp, M.D.
 H. C. Wallace, M.D.

MORGAN COUNTY

Leon Gray, M.D.
 Edward M. Pitkin, M.D.
 R. W. VanBokkelen, M.D.

NOBLE COUNTY

August L. Fipp, M.D.
 James B. Schutt, M.D.

ORANGE COUNTY

Philip T. Hodgins, M.D.
 William E. Schoolfield, M.D.

OWEN-MONROE COUNTIES

Frederick R. Brown, M.D.
 Naomi L. Dalton, M.D.
 Ambrose C. Estes, M.D.
 Eldred F. Hardtke, M.D.
 Philip T. Holland, M.D.
 William A. Karsell, M.D.
 R. E. Lyons, M.D.
 G. L. Mitchell, M.D.
 Anthony Pizzo, M.D.
 G. C. Poolitson, M.D.
 Hugh S. Ramsey, M.D.
 William C. Reed, M.D.
 Ben R. Ross, M.D.
 Herschel S. Smith, M.D.
 W. J. Stangle, M.D.
 James N. Topoligus, M.D.
 T. L. Wilson, M.D.

PARKE-VERMILION COUNTIES

W. D. Britton, M.D.
 P. B. Casebeer, M.D.
 F. J. Evans, M.D.
 Casper Harstad, M.D.
 Dorothy E. Lauer, M.D.
 *N. B. Rosenfeld, M.D.

PERRY COUNTY

Hardin S. Dome, M.D.
 David A. Dukes, M.D.
 Donald L. Lashley, M.D.
 Lewis C. Lohoff, M.D.
 Noel L. Neifert, M.D.

PIKE COUNTY

J. L. Higgins, M.D.
 *T. R. Rice, M.D.

PORTER COUNTY

Ralph C. Eades, M.D.
 J. R. Frank, M.D.
 William C. Robertson, M.D.

POSEY COUNTY

Paul R. Boren, M.D.
 L. R. Thompson, M.D.

PULASKI COUNTY

Charles E. Linton, M.D.

PUTNAM COUNTY

L. F. Gwaltney, M.D.
 J. B. Johnson, M.D.
 A. S. Nichols, M.D.
 G. D. Rhea, M.D.
 Edgar E. Richards, M.D.
 Dick J. Steele, M.D.
 George T. Tennis, M.D.
 L. W. Veach, M.D.
 R. L. Veach, M.D.
 V. Earle Wiseman, M.D.

RANDOLPH COUNTY

I. E. Brenner, M.D.
 A. T. Henderson, M.D.
 Charles E. Martin, M.D.
 Lowell W. Painter, M.D.
 Robert W. Reid, M.D.
 John S. Robinson, M.D.
 Henry R. Shallenberger, M.D.
 C. R. Slick, M.D.
 B. F. Wills, M.D.

RIPLEY COUNTY

Henry W. Conrad, M.D.
 Charles F. Fletcher, M.D.
 Lloyd W. Hisrich, M.D.
 L. H. Hopkins, M.D.
 Lowell G. Hunter, M.D.

* Deceased

William C. McConnell, M.D.
 George S. Row, M.D.
 R. Lee Smith, M.D.

RUSH COUNTY

C. C. Atkins, M.D.
 Donald J. Dean, M.D.
 Davis W. Ellis, M.D.
 Frank H. Green, M.D.
 R. O. Kennedy, M.D.
 C. Willard Worth, M.D.

ST. JOSEPH COUNTY

Morris Balla, M.D.
 Charles Baran, M.D.
 Jene R. Bennett, M.D.
 Benedict A. Biasini, M.D.
 David A. Bickel, M.D.
 L. C. Bixler, M.D.
 L. M. Bodnar, M.D.
 Harvey J. Brechtel, M.D.
 W. D. Buchanan, M.D.
 F. R. N. Carter, M.D.
 James V. Cassidy, M.D.
 William H. Clark, M.D.
 David H. Condit, M.D.
 C. S. Culbertson, M.D.
 R. H. Denham, M.D.
 Ernest L. Dietl, M.D.
 Robert D. Dodd, M.D.
 Bernard J. Dolezal, M.D.
 D. L. Dunlap, M.D.
 B. E. Edwards, M.D.
 S. L. Egan, M.D.
 Alfred Ellison, M.D.
 J. P. English, M.D.
 L. G. Ericksen, M.D.
 Gustaf W. Erickson, M.D.
 Max Feldman, M.D.
 Edson C. Fish, M.D.
 D. W. Frash, M.D.
 William B. Frey, M.D.
 M. S. Friedman, M.D.
 Gladys Frith, M.D.
 Louis Frith, M.D.
 George E. Gates, M.D.
 A. S. Giordano, M.D.
 *J. M. Gordon, M.D.
 George F. Green, M.D.
 Norval E. Green, M.D.
 Donald Grillo, M.D.
 P. E. Haley, M.D.
 Charles O. Hamilton, M.D.
 H. W. Helmen, M.D.
 M. W. Hillman, M.D.
 Lillian S. Holdeman, M.D.
 R. W. Holdeman, M.D.
 D. S. Houser, M.D.
 Charles O. Joest, M.D.
 John W. Karn, M.D.
 A. A. Kramer, M.D.
 John E. Krueger, M.D.
 Frederick L. Kuhn, M.D.
 William H. Lane, M.D.
 John R. Lionberger, M.D.
 Emanuel C. Liss, M.D.
 Philip B. Lockhart, M.D.
 Howard M. Luginbill, M.D.
 Corley B. McFarland, M.D.
 Charles F. Martin, M.D.
 Eugene C. Murphy, M.D.
 Josephine F. Murphy, M.D.
 George Nassef, M.D.
 Raymond E. Nelson, M.D.
 Kenneth L. Olson, M.D.
 W. R. Orr, M.D.
 George Plain, M.D.
 Thomas B. Pauszek, M.D.
 Andrew Petrass, M.D.
 Thomas P. Potter, M.D.
 H. D. Pyle, M.D.
 Ruth F. Rasmussen, M.D.
 George Rosenheimer, M.D.
 Jacob Rosenwasser, M.D.
 Eli Rubens, M.D.
 C. J. Rudolph, M.D.
 K. E. Selby, M.D.
 R. L. Sensenich, M.D.
 Merle C. Sharp, M.D.
 E. M. Sirlin, M.D.
 Wendell L. Spalding, M.D.
 D. D. Stiver, M.D.
 H. A. Staunton, M.D.
 J. S. Stratigos, M.D.
 A. R. Templeton, M.D.
 John M. Thompson, M.D.
 R. A. Thompson, M.D.
 M. J. Thornton, M.D.
 F. J. Vurpillat, M.D.
 A. M. Wilhelm, M.D.
 Irvin Zeiger, M.D.

SCOTT COUNTY

Carl R. Bogardus, M.D.
 Marvin L. McClain, M.D.
 Floyd S. Napper, M.D.

SHELBY COUNTY

Gustus S. Billman, M.D.
 W. L. Dalton, M.D.
 H. H. Inlow, M.D.
 William D. Inlow, M.D.
 Vernon C. Patton, M.D.
 N. F. Richard, M.D.
 Roger F. Whitcomb, M.D.

STARKE COUNTY

J. F. DeNaut, M.D.
 Guy B. Ingwell, M.D.
 Earl R. Leinbach, M.D.
 J. R. Matthew, M.D.

SULLIVAN COUNTY

*H. E. Bland, M.D.
 C. F. Briggs, M.D.

TIPPECANOE COUNTY

C. H. Ade, M.D.
 Mary Keller Ade, M.D.
 J. C. Burkle, M.D.
 Raymond R. Calvert, M.D.
 Ira Cole, M.D.
 F. S. Crockett, M.D.
 George R. Donahue, M.D.
 Ramon E. DuBois, M.D.
 James E. Engeler, M.D.
 Russell A. Flack, M.D.
 M. G. Frasn, M.D.
 Lloyd J. Holladay, M.D.
 David M. Jones, M.D.
 Harry E. Klepinger, M.D.
 Harry J. Laws, M.D.
 K. F. Laws, M.D.
 D. C. McClelland, M.D.
 R. E. Miller, M.D.
 F. W. Ratcliff, M.D.
 Philip W. Rothrock, M.D.
 William M. Sholtz, M.D.
 Gordon A. Thomas, M.D.
 C. J. Trout, M.D.
 R. W. Vermilya, M.D.

TIPTON COUNTY

Boyd A. Burkhardt, M.D.
 Jean V. Carter, M.D.
 Stanley M. Cotton, M.D.
 Harold L. Ericson, M.D.
 A. E. Stouder, M.D.

VANDEBURGH COUNTY

Herman M. Baker, M.D.
 R. W. Boswell, M.D.
 D. F. Buehner, M.D.
 Stanton L. Bryan, M.D.
 C. R. Buikstra, M.D.
 John H. Combs, M.D.
 Paul D. Crimm, M.D.
 Melvin S. Durkee, M.D.
 Henry J. Faul, M.D.
 E. L. Fitzsimmons, M.D.
 Gordon T. Herrman, M.D.
 C. C. Herzer, M.D.
 G. C. Johnson, M.D.
 Stephen L. Johnson, M.D.
 Frederick L. Kiechle, M.D.
 R. L. Kleindorfer, M.D.
 Clarence A. Laubscher, M.D.
 Robert J. Miller, M.D.
 Adeline F. Muelchi, M.D.
 Alfred Niedermayer, M.D.
 Walter S. Pollard, M.D.
 Isidor Raphael, M.D.
 R. J. Rossow, M.D.
 H. C. Ruddick, M.D.
 John C. Slaughter, M.D.
 W. D. Snively, Jr., M.D.
 D. C. Tweedall, M.D.
 J. W. Visher, M.D.
 Henry G. Weiss, M.D.
 Thomas Wesson, M.D.
 Kenneth Wilhelmus, M.D.
 G. W. Willison, M.D.
 John D. Wilson, M.D.
 Shelby W. Wishart, M.D.
 W. P. Woods, M.D.
 Harold Zimmerman, M.D.

VIGO COUNTY

L. L. Blum, M.D.
 Robert R. Brown, M.D.
 A. W. Cavins, M.D.

Eugen Eisenlohr, M.D.
D. A. Gerrish, M.D.
Hubert T. Goodman, M.D.
Paul E. Humphrey, M.D.
R. N. Kabel, M.D.
William W. Kriebel, M.D.
Joseph Kunkler, M.D.
William C. Kunkler, M.D.
Noel S. McBride, M.D.
*A. M. Mitchell, M.D.
Jury B. Loving, M.D.
G. G. Musselman, M.D.
E. O. Nay, M.D.
Louis G. Neudorff, M.D.
Roy V. Pearce, M.D.
Robert C. Reed, M.D.
J. V. Richart, M.D.
Floyd C. Riggs, M.D.
Burton E. Scherb, M.D.
M. C. Topping, M.D.
E. C. Voges, M.D.

WABASH COUNTY

O. G. Brubaker, M.D.
J. G. Kidd, M.D.
William E. Pearson, M.D.
G. W. Seward, M.D.
J. T. Steffen, M.D.
James L. Walker, M.D.

WARRICK COUNTY

W. C. Stover, M.D.

WASHINGTON COUNTY

I. E. Huckleberry, M.D.
T. Kermit Tower, M.D.

WAYNE-UNION COUNTIES

Frank B. Adney, M.D.
H. E. Allen, M.D.
R. T. Allen, M.D.
Paul W. Blossom, M.D.
Frank H. Coble, M.D.
Leon T. Cox, M.D.
Rolfe A. Heck, M.D.
D. R. Hutchison, M.D.
George M. Johnson, M.D.
Glen Ward Lee, M.D.
Charles H. Loomis, M.D.
Russell L. Malcolm, M.D.
W. B. McWilliams, M.D.
E. J. Meredith, M.D.
Harry P. Ross, M.D.
P. W. Runge, M.D.
Morris C. Snyder, M.D.
Will A. Thompson, M.D.
Horace Wanninger, M.D.
Francis B. Warrick, M.D.
Arthur J. Whallon, M.D.
M. W. Yencer, M.D.

WELLS COUNTY

H. B. Annis, M.D.
C. J. Aucreman, M.D.
H. D. Brickley, M.D.
Harold D. Caylor, M.D.
Truman E. Caylor, M.D.
Robert G. Cook, M.D.
M. A. Davidoff, M.D.
T. O. Dorrance, M.D.
Jack L. Eisaman, M.D.
W. E. Hardin, M.D.
Charles E. Jackson, M.D.
Robert L. Johnston, M.D.
S. Bruce Kephart, M.D.

Allen C. Nickel, M.D.
R. M. Sherman, M.D.
John A. Shively, M.D.
Pierre C. Talbert, M.D.
Wallace S. Tirman, M.D.
Richard P. Yoder, M.D.

WHITE COUNTY

S. E. McClure, M.D.
Warren V. Morris, M.D.

WHITLEY COUNTY

C. Jules Heritier, M.D.
John L. Langohr, M.D.

OUT OF STATE

J. Colin Elliott, M.D., Buchanan, Mich.
John E. Graf, M.D., Chicago, Illinois
Laurence E. Jewett, M.D., Excelsior Springs, Missouri
Flavius Ullrey, M.D., Hamilton, Ohio
T. O. Middleton, M.D., Ft. Benning, Ga.
D. H. Murray, M.D., Napa, California
Sydney S. Norwick, M.D., San Lorenzo, California

MISCELLANEOUS

Mrs. J. H. Eberwein, Indianapolis
Elkhart County Medical Society
Indiana Academy of General Practice
Indianapolis Medical Society
Kosciusko County Medical Society
Tippecanoe County Medical Society
Whitley County Medical Society
Woman's Auxiliary to the Indiana State Medical Association

* Deceased



A Hospital for the
diagnosis and treatment
of nervous and mental
diseases, alcoholics and
drug cases.

There is a special
service for the aged,
the convalescent or
anyone desiring
Nursing Home care.

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North River Road

Phone 3-1679

J. MOSS BEELER, M.D.
Medical Director

ROY KINZER
Manager

Technical Exhibits

October 19, 20 and 21

8:00 a.m.—5:30 p.m.—Monday and Tuesday

8:00 a.m.—4:00 p.m.—Wednesday

Booth COMPANY and PRODUCTS

15 Abbott Laboratories, North Chicago, Ill.

Abbott will display SULESTREX Piperazine tablets for the control of symptoms of the climacteric. SULESTREX is a pure, odorless and tasteless compound which is rapidly hydrolyzed in the body. It provides rapid control of menopausal symptoms with an extremely low incidence of side-effects. SULESTREX is absolutely pure, crystalline estrogen, chemically standardized for unvarying hormonal activity. Because SULESTREX is absolutely pure, it can never impart an odor to the breath or perspiration. The pure inorganic salts of estrone sulfate are combined with piperazine to form a stable, water-soluble, crystalline salt. It is as effective estrogen therapy as it is presently possible to prescribe.

23 Akron Surgical House, Inc., Indianapolis

Clarence Lippott, Ed Hallyburton

Members of the Indiana State Medical Association and their guests are invited to visit our booth. Our representatives, Clarence Lippott and Ed Hallyburton, will be pleased to discuss any products in which you may be interested.

42 A. S. Aloe Company, St. Louis, Mo.

Visit Booth No. 42 where the Aloe representative will show you a cross section of the complete line of physicians' equipment and supplies carried by the A. S. Aloe Company. Highlighted will be New Model Steeline—tomorrow's treatment room furniture today—featuring the body contour table top, magnetic door catches and advanced design all in new decorators' colors.

43 American Hospital Supply Corporation, Evanston, Ill.

American Hospital Supply Corporation will exhibit Baxter intravenous solutions including Travert, the new invert sugar solution providing twice the calories as Dextrose in the same infusion time; Baxter blood transfusion and plasma equipment, together with the complete line of Baxter expendable accessories for the intravenous solutions and blood and plasma bottles.

28 Ames Company, Inc., Elkhart, Indiana

Robert F. Myers, Nathan W. Edens, Charles E. Rhyne

AMES COMPANY, INC., presents,

APAMIDE, (Brand of N-acetyl-p-aminophenol) is a new direct acting analgesic and antipyretic offering prompt prolonged relief of pain and reduction of fever.

APROMAL, (Brand of N-acetyl-p-aminophenol and acetylcarbromal) combines the direct analgesic-antipyretic action of APAMIDE with the gentle sedative action of acetylcarbromal.

Booth COMPANY and PRODUCTS

ICTOTEST, new diagnostic tablet test for detection of urine bilirubin will be demonstrated.

49 Barlow-Maney Laboratories, Inc., Cedar Rapids, Iowa

Francis A. Tougaw, Harry Diman, Charlie Rogers, Wm. E. Tougaw

Barlow-Maney Laboratories will feature its new drug Neothylline (dihydroxypropyl theophylline). In presenting Neothylline Barlow-Maney will exhibit the first Neutral, Soluble, Stable Theophylline Derivative with the therapeutic effect of Aminophylline and other active Theophylline derivatives now on the market, but without their untoward effects. Samples and literature on this product will be available.

29 Beech-Nut Packing Company, New York

The Beech-Nut Packing Company will again display its fine variety of Strained and Junior Baby Foods. In addition they are proud to present an innovation in the form of a 4-ounce box for the cereals. This has been accomplished for the convenience of the mothers and insurance of an always-fresh product for the babies.

25 Brooks Appliance Company, Chicago

W. C. Ayer, R. L. Ayer

The Brooks Appliance Company will exhibit and describe in detail the technique of applying the combination pressure bandages. The moist medicated Primer Bandage plus the Elastic Adhesive Dalzoflex Bandage which are used in treating leg ulcers and phlebitis. Elastic Stocking, the Nulast Elastic Crepe Bandage and Surgical Instruments will also be displayed.

51 Brown & Williamson Tobacco Corporation, Louisville

J. G. Crume, J. W. Shuler, S. S. Burnett

The exclusive Health-Guard Filter Tip in the VICEROY King Size Cigarette provides beneficial protection to the smoker. An authentic demonstration and an explanation of its unique advantages will be of real interest to all those who visit the VICEROY exhibit.

45 Burroughs Wellcome & Co. (U.S.A.) Inc., Tuckahoe, N.Y.

O. L. Ney, J. W. Bolton, R. O. Robinson

POLYSPORIN—Polymyxin B-Bacitracin Ointment. Broad spectrum antibacterial action, rarely sensitizes, resistance rarely develops.

AERODRIN brand INTRANASAL SOLUTION—Decongestion without stimulation—Broad-spectrum antiseptics.

Booth COMPANY and PRODUCTS**6-7 Camel Cigarettes, New York**

W. S. Smith, Jr., B. H. Crawford

CAMEL Cigarettes will mark your initials on an attractive plastic cigarette case filled with a package of those mild, flavorful CAMELS. This exhibit features a display of some of the tobaccos used in blending this famous cigarette which outsells all other brands by many billions of cigarettes per year.

34 Campbell Associates, Cincinnati**18 The Central Pharmacal Company, Seymour, Indiana**

J. L. Rogers, A. J. Stiles, W. W. Torrens

Our display will feature several new products that you will find interesting and helpful in solving a number of medical problems in better ways. These new specialties have been developed in accordance with our policy and slogan "Products Born of Continuous Research".

60 Chicago Pharmacal Company, Chicago

C. H. Taylor, Pres., Forest Willis, E. D. Cole

Chicago Pharmacal Company welcomes your visit to our booth No. 60, at which the following Chimedie specialties are featured: a Estradiol injectables, in both aqueous microsuspension and oil and in potencies from 10,000 I.U. to 50,000 I. U., packaged in protective amber vials and plastic caps insuring full potency at all times; CHIDES-TROL, a 50 mg. Diethylstilbestrol tablet, heading a complete diethylstilbestrol line in tablets and injectables; Calcium Levulinate ampuls 40% more potent in calcium content than the gluconate with the added advantage of being more stable and soluble in 10% solutions; URISED, nationally-known tablet for both antisepsis and sedation in genito-urinary infections; and TOLYPHY, the improved spasmolysis formula which combines the full therapeutic dose of mephenesin, N.N.R. with physostigmine and atropine, for complete relaxation of both skeletal and smooth muscle.

5 Ciba Pharmaceutical Products, Inc., Summit, N.J.

B. E. Fossieck, W. H. Cory, R. E. Addington

Ciba's exhibit (Booth No. 5) features two new agents for more effective management of hypertensive disorders—REGITINE, for simple and accurate diagnosis of hypertension produced by pheochromocytoma—APRESOLINE, an agent of choice for gradual sustained lowering of blood pressure.

You are invited to visit the Ciba booth for literature on APRESOLINE and REGITINE.

16-17 The Coca-Cola Company, Atlanta, Georgia

Ice cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company of Jasper, Inc. and The Coca-Cola Company.

Booth COMPANY and PRODUCTS**24 Curtis & French, Inc., Indianapolis**

Jack Curtis, Bob Ettinger, Mac McCain

The Curtis & French, Inc., organization, expects to show new items of interest in equipment, instruments and scientific apparatus. Jack Curtis, Bob Ettinger and Mac McCain will be in attendance waiting to serve the profession.

Mr. Fritz Landeur of the Tecca Corporation will demonstrate low voltage generators and electric diagnostic instruments.

31 Dairy Councils of Indiana, Indianapolis

Dairy Council health education materials will be on display. These materials are free of charge in the localities which have affiliated units.

The exhibit is sponsored by the Dairy Councils of Evansville, Fort Wayne, Indianapolis, Kokomo-Peru, and South Bend. These units are affiliated with the National Dairy Council of Chicago, which is the health education organization of the dairy industry.

1 Edison Clinical Recording, Van Ausdall & Farrar, Indianapolis

C. F. Farrar, C. J. Clarke

MEDICAL RECORDS BY EDISON

Last year we presented EDISON TELEVOICE!

Many Indiana hospitals have adopted this marvelous system and many of you are using it.

This year we proudly present the NEW EDISON V.P.—*Very Portable* Instrument—for recording medical records and correspondence in your office, your home, or in your car.

Available at low cost in Combination units—recording and transcribing on *same* instrument—or in separate recording and transcribing units. See it at Booth 1.

59 Encyclopedia Americana, Chicago

Armin Eastman, Lorraine Eastman

All members and guests of the Indiana State Medical Association are cordially invited to inspect the *New 1953 Edition* of the *Encyclopedia Americana*, and the *40th Anniversary Edition* of the *Book of Knowledge*, which will be on display in Booth 59.

36 Gerber Products Company, Fremont, Michigan

Harriett Davis, R.N., Russell Callahan, Donald Rasico

Gerber's Concentrated Meat Base Formula is NEW. It is prepared to replace milk in the allergic infant's diet. It will help assure a well-fed and happy baby.

Your Gerber detailman looks forward to showing you this important infant food. He also invites you to examine their COMPLETE line of baby foods. Up-to-date baby-care booklets are available for your office . . . Complimentary of course.

33 Freeman X-Ray Company, Chicago—Charles Freeman, Earl Hamren

Booth COMPANY and PRODUCTS**2 J. E. Hanger, Inc., Indianapolis**

M. G. Manwaring, J. M. Talbert, James Yount

J. E. Hanger, incorporated, for over ninety years designers and fabricators of prostheses for upper and lower extremity amputations, invites the members of the Indiana State Medical Association to attend their exhibit in Booth 2.

Our display will feature the latest developments in the prosthetic field including cosmetic restorations and the newly developed Army Prosthetic Research Laboratory mechanical hands and hooks as well as the improved suction socket limb for thigh amputation.

62-63 Hill-Rom Company, Inc., Batesville, Indiana

Wm. A. Hillenbrand, Pres.

The most practical type of hospital bed is being exhibited, one which may be raised and lowered electrically. The switch is placed behind the headboard in such a position that the patient himself may possibly adjust the height from domestic to standard hospital bed height. This as well as other items are made in a combination of wood and metal and includes a crank adjustable single pedestal overbed table. Straight Chairs that do not strike the wall and of course the ever popular Hill-Rom floor lamp are also being shown in various colors. This is equipment that you certainly will want to see from the standpoint that it is also ideal for use in homes as well as hospitals.

20 Hoffmann-LaRoche Inc., Nutley, New Jersey

Herod Rains

You will find three products featured in the Roche display: ASTEROL, a new, practically odorless antifungal agent for ringworm of the skin, hair and nails; GANTRISIN, a more soluble, single sulfonamide which provides a wider antibacterial spectrum in systemic and urinary infections and RONIACOL, a new well-tolerated vasodilator which is useful in vascular disorders and in some cases of angina pectoris.

38 Kremers-Urban Co., Milwaukee

Welcome to the K-U booth. New medications featured will be Kused for sedation all along the line; Salmeph-C for relief of the pain-spasm cycle in rheumatoid arthritis and related conditions. New clinical data on Kutapressin will be available.

8 Lederle Laboratories Division,

American Cyanamid Company, New York

You are cordially invited to visit our exhibit in space No. 8 where you will find our representatives prepared to give you the latest information on LEDERLE products.

Booth COMPANY and PRODUCTS**39 Eli Lilly and Company, Indianapolis**

Harley Chastain, W. M. Gay, C. W. Clark

You are cordially invited to visit the Lilly exhibit located in space number 39. Antibiotics, cardiac drugs, and antihistamines are featured in the display. Lilly salesmen will welcome your questions about these and other recent therapeutic developments.

10 J. B. Lippincott Company, Philadelphia

John E. Lagle

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

61 P. Lorillard Company, New York

C. W. White, A. C. Cushing, E. J. Rohmer

P. Lorillard Company, manufacturers of OLD GOLD and EMBASSY cigarettes as well as BRIGGS Pipe Mixture and other famous tobacco products will exhibit and demonstrate their new KENT Cigarettes with the exclusive Micronite Filter, which takes out up to 7 times more nicotine and tars than other filter cigarettes.

9 M & R Laboratories, Inc., Columbus, Ohio

John Reed, Joe O'Rourke, Bob Wilson

Your SIMILAC representatives are happy to take part in this meeting. They are pleased to have the opportunity to discuss with you the role of SIMILAC in infant feeding. They have for you the latest Pediatric Research Conference Reports. Also available are current reprints of pediatric nutritional interest.

55 McNamara Medical Equipment Co., Detroit

Gerald McNamara, Albert Perior

Medcolator treatment is electrical muscle stimulation which promotes decongestion and healing, through muscle contraction. An ancillary to massage, heat treatment or drugs and effective alone in most cases where these other modalities may be contraindicated or have a tendency to increase pain.

The following is an excerpt from page 247, A.M.A. Handbook of Physical Medicine and Rehabilitation:

"Electrical Muscle Stimulation is a valuable form of therapy for use in the treatment of strains, sprains, and dislocations. The object of the treatment is to assist in the removal and resolution of the vascular and lymphatic exudates which form as a result of trauma to the small arterioles and lymph channels."

Booth COMPANY and PRODUCTS**21 The S. E. Massengill Company, Bristol, Tenn.**

R. Gojkovich, E. L. Smith, M. W. Pully

You are cordially invited to visit Booth No. 21 where several specialty products are on display. Massengill medical service representatives are glad to discuss these with you and your particular attention is called to the new systemic hemostat Adrenosem.

Adrenosem is specific for conditions characterized by increased capillary fragility and permeability. It is a therapeutically effective agent of extremely low toxicity and is indicated in treating idiopathic purpura, retinal hemorrhage, familial telangiectasia, and bleeding control of surgery. Representatives have complete information on this new preparation and will be glad to provide you with recent clinical information on Adrenosem.

37 Mead Johnson & Company, Evansville

Paul G. Bickell, O. L. Miller

Mead Johnson & Company, Evansville, Indiana, Booth No. 37, will feature Dextri-Maltose, the carbohydrate of choice in infant formulas; Lactum, Mead's complete liquid formula; and Olac, Mead's complete powdered formula. Also to be featured will be Natalins, the new smaller prenatal capsule; vitamin products for Infants and children, Poly-Vi-Sol, Tri-Vi-Sol and Mulcin; and the four Pabulum Cereals.

Representatives in attendance will be glad to furnish information regarding the above products.

41 The Medical Protective Company, Fort Wayne

Byard H. Smith, Kenneth W. Moeller

The "Know-how" in Defense and Proven Protection against Loss that have made The Medical Protective Company pre-eminent in the Professional Liability field for more than half a century are linked with the superiority of the Company's time proven plan of Individual Professional Protection which is unhampered by underwriting and protection failures, such as prevail elsewhere with Large Limit and Society Group underwriting. Authoritative answers to questions arising out of the Doctor-Patient relationship and information on proper protection for it may be obtained at Booth No. 41 from a Company representative who has had the special training and long experience that are indispensable in this field. The Integrity of The Medical Protective Company matches that of the profession it serves.

Booth COMPANY and PRODUCTS**64 Bill Moss, Inc., Bloomington**

Bill Moss, Inc., Bloomington, Indiana, catering to the dispensing physician will display injectables, tablets, and liquids at the Indiana State Medical Convention, French Lick, Indiana, on October 19, 20, 21, featuring the following items:

Aqueous Hormones U. S. P.

Cetrizine, the new triple sulfa liquid and tablet. Vicholex, the elixir and tablet dietary supplement of Choline, B12, Methionine with minerals and the B complex added.

Hyatal, the liquid and tablet anti-spasmodic treatment.

Verital, the hypertensive vasodilator of Veratrum Veride, Sodium Nitrite and Phenobarbital.

B12—100 mcgs. per cc and 1000 mcgs. per cc. Crystivolid; Liver, B12, and Folic Acid in a therapeutic combination.

53 Mutual Medical Insurance, Inc. (The Blue Shield Plan), Indianapolis

R. S. Saylor, L. E. Converse, Guy W. Spring

Mutual Medical Insurance, Inc. (Blue Shield Plan) will have its exhibit in Booth No. 53.

Representatives of the Plan will be on hand at all times to answer questions and be helpful in any way possible. Special materials will be distributed explaining the operation of the Plan, the benefits it affords the physician and the public, and showing the growth of the Plan in membership during the past five years.

Dr. Walter U. Kennedy, New Castle, is president of the Blue Shield Plan; Dr. W. Harry Howard, Hammond, is vice-president; Dr. Walter L. Porteus, Franklin, is secretary; and Mr. Elmer W. Stout, Indianapolis, treasurer.

Administration of The Blue Shield Plan is under the direction of R. S. Saylor, Executive Vice-President, 500 Terminal Building, Indianapolis.

68 Ortho Pharmaceutical Corporation, Raritan, N.J.

ORTHO cordially invites you to booth 68 where the well known line of obstetrical and gynecological pharmaceuticals will be on display. Particular emphasis will be placed on Ortho preparations for conception control. Ortho representatives will be on hand to offer pertinent information on their products.

Booth COMPANY and PRODUCTS**52 Orthopedic Frame Company, Kalamazoo**

G. D. Flora

The Orthopedic Frame Company, located in booth No. 52, will demonstrate the reliable Stryker Turning Frame. All latest improvements and accessories will be shown. New operational and instructional booklets will be distributed at the booth.

Also shown will be the three Stryker safety saws: the Cast Cutter, Autopsy Saw and the Combination Bone Saw and Dermatome.

35 Parke, Davis & Company, Detroit

B. S. Pearce, M. O. Hollingsworth

A cordial welcome awaits you at the Parke-Davis booth. Members of our Medical Service Staff will be on hand to greet you and discuss any of our products in which you may be particularly interested.

14 Pet Milk Company, St. Louis, Mo.

Specially trained representatives will be in attendance to discuss the use of Pet Evaporated Milk in infant feeding and Pet Nonfat Dry Milk for high protein diets. A variety of services that are timesavers for busy physicians will be furnished on request. Miniature Pet Milk cans will be given to visitors at the exhibit.

40 Chas. Pfizer & Co., Inc., Brooklyn, N.Y.

You are cordially invited to visit the Pfizer booth where you will find well-informed representatives who will be happy to supply you with information and answer any questions relative to Pfizer Products. Terramycin dosage forms will be the feature attraction of the Pfizer exhibit.

44 Pitman-Moore Company, Indianapolis

W. C. McCrory, Edwin Bowlen, Paul Wyand, L. E. Davis

Pitman-Moore Company will feature in its exhibit Veralba Tablets for the control of hypertension. This drug, recently established as one of the most potent and best tolerated of the veratrum derivatives, is composed of protoveratrine A and protoveratrine B in quantities standardized by an original Pitman-Moore chemical assay. Veralba, which has recently been accepted by the Council on Pharmacy and Chemistry, has been broadly evaluated and should be of genuine interest to all members of the Association.

Booth COMPANY and PRODUCTS**3 Rex Typewriter Exchange, Indianapolis**

Curt Benner, Jan Eden

Be sure to visit the Rex Typewriter Exchange booth. We will have on display all the latest models of Webster Chicago Wire Recorders and Tape Recorders. See the new Model 228 Dictation wire recorder, with push to talk microphone, two-way foot control with back spacer, and other new features. Also see the new Model 210 Tape Recorder that records up to two hours, and has fast forward and fast reverse speeds for your convenience. The new model 228 Wire Recorder will fit all your dictating and transcribing needs at a very low cost.

Also on display will be adding machines and typewriters, suitable for physicians' offices.

Curt Benner and Jan Eden will have charge of the display.

19 Rickrich Surgical Supply Company, Evansville

G. F. Carter, John Stephens, I. J. Rickrich

A cordial invitation is extended to all physicians to visit our display in Booth No. 19. Many new items will be shown.

George F. Carter, John Stephens and I. J. Rickrich will be there to greet you.

11 A. H. Robins Company, Inc., Richmond, Va.

D. W. Otoupal, R. M. Stitt, L. E. Heinmiller

The A. H. Robins Company exhibit features Robalate, N.N.R. antacid-demulcent indicated in peptic ulcer therapy and hyperacidity. The pharmaceutically elegant tablets, each containing 0.5 gm. dihydroxy aluminum aminoacetate, are notable for exceptional palatability.

13 Sandoz Pharmaceuticals, Division of Sandoz Chemical Works, Inc., New York

CAFERGOT the first effective oral therapy for migraine and related vascular headaches—clinically proven in thousands of reported cases since 1949.

BELLERGAL valuable as an autonomic inhibitor in a variety of functional ills—the volume of favorable clinical reports is constantly increasing. HYDERGINE a new approach and new product for hypertension and peripheral vascular diseases. FIORINAL a new approach to therapy of tension headache and other head pain due to sinusitis and myalgia.

A variety of informational brochures will be available and our representatives will be happy to provide full information concerning the above and other ethical pharmaceutical products of the Sandoz organization.

Booth COMPANY and PRODUCTS**30 W. B. Saunders Company, Philadelphia**

Sherman E. Perkins, Gerald E. Miller

Among our books of interest to the practicing physician, new and not available until recently, are: Bakwin's and Bakwin's Clinical Management of Behavior Disorders in Children; Parsons & Ulfelder's Atlas of Pelvic Operations; A.M.A.'s Fundamentals of Anesthesia; Gross' Surgery of Infancy and Childhood; Cattell & Warren's Surgery of the Pancreas; and many others.

Included also will be Saunders standards such as Cecil-Loeb's Textbook of Medicine; Mitchell-Nelson's Pediatrics; Dorland's Dictionary; and the Medical and Surgical Clinics of North America. Ask for literature on the forthcoming Pediatric Clinics of North America.

46 Schering Corporation, Bloomfield, N.J.

Edwin Leinhos, James Klein

Members of the Indiana State Medical Association and their guests are cordially invited to visit the Schering exhibit where new therapeutic developments will be featured.

Schering representatives will be present to welcome you and to discuss with you these products of our manufacture.

47 G. D. Searle & Co., Chicago

Dr. LaRue E. Davis, G. A. Yotter, R. W. Schulz, Edward Rinderknecht

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Vallestiril, the new synthetic estrogen with extremely low incidence of side reactions; Banthine, and Pro-Banthine, the standards in anti-cholinergic therapy; and Dramamine, for the prevention and treatment of motion sickness and other nausea.

57-58 Servel, Inc., Evansville

Neal E. Schuman, George L. Beyers, David K. Patterson, Elvis J. Oakley, Joseph T. Mooney

Two Indiana-made temperature-control products will be shown in Spaces Nos. 57 and 58 by Servel, Inc., of Evansville, Ind. These products are the Servel electric Wonderbar and the Servel room air conditioner.

The Servel electric Wonderbar is a silent portable refrigerette, which is styled like smart furniture for use in the office or in any room of the home. It is available in white, blonde or mahogany finish. It provides 1.31 cubic feet of refrigerated storage capacity, and freezes two trays of ice cubes at a time. It is available with or without legs and casters. The freezing system is of the Servel electric absorption type, which has no moving parts and is completely silent.

The Servel room air conditioner, which is a window-type unit, provides clean, cool, dehumidified

Booth COMPANY and PRODUCTS

air for offices and waiting rooms. The cabinet is styled like furniture, and is made in mahogany finish or beige finish.

It is made in two capacities— $\frac{3}{4}$ horsepower and 1 horsepower. It has a single finger-tip dial which controls all of the functions of the air conditioner.

65 Seven-Up Bottling Company, Indianapolis

For nearly twenty years Seven-Up, the "Fresh-Up" drink, has been a part of the Indiana scene. For much of that time our booths have contributed to the success of the Indiana State Medical Conventions each year.

Seven-Up has many friends among medical association members who attend these conventions. We like to greet our old friends here, and we like to make new friends each year.

At the end of a session, visit our booth for a "Fresh-Up". A chilled bottle of tingling, sparkling Seven-Up will put you in shape for the next session. Remember—You like it, it likes you.

Throughout Indiana wherever you live, you will find Seven-Up. Our plants are located in Indianapolis, Fort Wayne, South Bend, Gary, Lafayette, Terre Haute, Richmond, Evansville and French Lick.

Company branches are located in Kokomo, Anderson, Plymouth, Bloomington, Bedford, Vincennes, Seymour, Aurora and many other cities. Seven-Up is *always* sold in bottles—never in any other way.

Your host at the Convention—

TOM JOYCE

67 Spencer Supports, Indianapolis

Madge L. Robbins, Mabel P. Parsons

You are invited to see the display of Spencer Supports—individually designed for each patient to improve body mechanics and thus aid treatment.

Of special interest are Spencer designs of proven clinical effectiveness in treatment of angina pectoris, postural hypotension and chronic arthritis.

Various posture-improvement and orthopedic supports are on display.

Ask for information on Spencer Breast supports designed for each individual need including antepartum, postpartum, ptosis, hypertrophy and mastectomy.

26-27 E. R. Squibb & Sons, Division of Mathieson Chemical Corporation, New York

W. D. Sears, T. L. Howard, H. J. Fry, J. R. Cook

New Squibb Products, and new brochures of useful interest to you on products already introduced, will be featured at Booths No. 26 and 27. As in former years, your Squibb Representative again cordially invites you to visit the Squibb Booth.

Booth COMPANY and PRODUCTS**4 The Stuart Company, Pasadena, Calif., and Chicago**

Ward Jackson, George Boylan

You are cordially invited to visit our exhibit where you will find our representatives prepared to give you the latest information on Stuart Products.

48 Testagar & Co., Inc., Detroit

William R. Proctor, Marshall Witzel, Louis E. Dixon

The professional service representatives of Testagar & Co., Inc., will be very pleased to welcome their many friends to view many new modern developments in the pharmaceutical field which will be displayed at Booth No. 48. Testagar representatives will introduce our latest development in antacid-antispasmodic therapy. An entirely new concept in antacid therapy will be presented. Also will be on display, a complete line of vials and ampuls and other pharmaceutical products. Requests for samples, literature and technical information will be quite welcome.

66 S. J. Tutag & Company, Detroit

S. J. Tutag, Edward Tutag, Jack Marx, M. G. Bentley

Featured in the S. J. Tutag & Company display, Booth 66, is the outstanding relaxant developed for both mind and body, SAL MEPHSON.

An excellent formula that embodies the property of a parasympathomimetic, a muscle relaxant, anti-spasmodic and an analgesic, Sal Mephson is extremely well balanced. It offers the physician a well founded therapeutic in cases of low back pain, spastic arthritis, bursitis, alcoholism, spondylitis and facial tic. The busy practitioner will find that Sal Mephson has great value also in Parkinsonism, multiple sclerosis, hemiplegia, paraplegia, diplegia and cerebral palsy. Containing Mephson, (Tutag's council accepted Mephenesin) it has some antipyretic qualities.

Also to be shown are the items of Tutag's obesity line.

To the conventioneer, visiting the booth, we will present a complimentary bar of the new TX-11, the antiseptic soap containing Actemer in a coconut oil base, the great new degerming agent recently developed. TX-11 is made by an exclusive triple milled process making it the finest in both hard and soft water.

51 The Upjohn Company, Kalamazoo

H. H. Arnholter, A. E. Clarke, S. Cullop, Jr., M. G. Edwards, C. W. Fiscus, W. D. Mottar, H. D. Nelson

The importance of Cortisone is expanding as clinicians discover new applications. The Upjohn Company is justly proud of its part in the development of Cortisone and in its discovery of new production methods. It is our aim to make Cortisone available to ever increasing numbers. Competent representatives welcome your inquiries and discussion.

Booth COMPANY and PRODUCTS**22 U. S. Vitamin Corporation, New York**

Exhibit features original, complete lipotropic therapy . . . METHISCHOL . . . the combination of five proven lipotropic agents: B12, choline, methionine, inositol and liver extract. Therapeutically effective in the treatment of hypercholesterolemia as associated with atherosclerosis, coronary disease, obesity, diabetes and various forms of liver disease, including liver cirrhosis and toxic hepatitis.

50 Warner-Chilcott Laboratories, Division of Warner-Hudnut, Inc., New York

R. E. Lindenmuth, J. J. McDonough, C. D. Neibel

Research and sales personnel will welcome an opportunity to discuss two important cardiovascular agents: Methium, an oral hypotensive, and Peritrate, a vasodilator for prophylaxis in angina pectoris.

Attention is invited to Gelusil, the drug of choice for many years for acid control in peptic ulcer without constipation.

32 The Warren-Teed Products Company, Columbus, Ohio

R. L. Sayre, H. H. Lammey, M. E. Davis

The Warren-Teed Products Company cordially invites you to visit their exhibit at booth No. 32. Featured will be Testeed Tablets (a balanced androgen-estrogen) and Glu-Sal Tablets, which represent a new and sound approach to the treatment of certain rheumatic, arthritic and neuralgic disorders.

56 The White-Haines Optical Company, Indianapolis

Clyde Lorton, Jack Gale

White-Haines will exhibit at the Indiana State Medical Convention occupying Booth No. 56. The booth will be attended by Clyde Lorton and Jack Gale.

Ophthalmic diagnostic equipment of interest to GP's as well as ophthalmologists, will be on display. Of special interest to general medical doctors will be Bausch & Lomb's Portable Slit Lamp—a highly efficient instrument for general and eye illumination. Of particular interest to the ophthalmologist will be a display showing some of the newer developments in presbyopic, post cataract and safety lenses.

12 Winthrop-Stearns, Inc., New York

Moody Cross, Joseph E. Hartman, Chester Knott, D. A. Blomgren

WINTHROP-STEARNES, INC., New York, extends a cordial invitation to visit booth No. 12, where representatives will be on hand to discuss the latest pharmaceutical preparations made by this firm. Featured will be FERGON PLUS, a combination of the important anti-anemia factors, Vitamin B12, Folic Acid, Ferrous Gluconate and Ascorbic Acid. It is designed specifically for the prep and therapy of iron deficiency and macrocytic anemias; ALEVAIRE, nontoxic inhalant which thins sticky pulmonary secretions in bronchitis, bronchiectasis, and neo-natal asphyxia; APOLAMINE, new synergistic compound, for more efficient control of nausea and vomiting due to pregnancy, radiation sickness, and other causes.

EMMETT B. LAMB, M.D., HONORED FOR WORK WITH PHYSICALLY HANDICAPPED

A "Citation for Outstanding Service" has been awarded to Dr. Emmett B. Lamb, Indianapolis, as the result of his selection by the Governor's Committee for Employment of the Physically Handicapped as Indiana's candidate for the national Physician's Award. The national honor goes to the physician selected by the President's Committee as the individual who has made the most outstanding contribution to the employment welfare of the physically handicapped of the nation.

Doctor Lamb, physician and surgeon who specializes in industrial cases, was presented the state citation in a recent ceremony by William C. Stalnaker, chairman of the Governor's Committee.

Shoes and Arches

Careful consideration given to Doctors' prescriptions for correct shoes, padding, braces, bars, wedges, heels, extensions, corrections and hand-made shoes for deformed feet.

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U. of Oklahoma Issues 1953-54 PG Program

The Office of Postgraduate Instruction at the University of Oklahoma has scheduled the following postgraduate courses for 1953-54 and will issue details on speakers later.

Surgical Pathology begins October 2; Internal Medicine, October 6; Surgery, December 9, 10 and 11; Psychiatry, December 28 and 29; Obstetrical-Gynecological Society annual meeting, January 16; Pediatrics, January 28, 29 and 30; Electrocardiography, March 1 through 6; General Surgery, March 2; Eye, Ear, Nose and Throat, March 26; Trauma, April 2 and 3; Internal Medicine, April 7, 8 and 9 and Radiology, May 7 and 8.

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in the Hills

French Lick Springs Hotel

W. O. SEELBACH, *General Manager*

C. J. THANNHAUSEN, *Sales Manager*

REPORTING COMMUNICABLE DISEASES IS A JOINT RESPONSIBILITY

A. L. MARSHALL, JR., M.D.*

Indianapolis

THE PROMPT REPORTING of all communicable disease (within 24 hours) to the local health officer is provided for by statute and regulations. (Chapter 157, Acts of 1949, Section 801; Regulations HCD 2, 3, 4, and 5.) Responsibility for reporting is placed equally upon the physician and the administrative officer of a hospital or institution. Through misunderstanding many physicians assume these cases are reported by the hospital. As a result many cases are never *officially* reported.

The cooperation of all physicians is requested in ascertaining that all cases of communicable disease that they hospitalize are reported to the health officer of the jurisdiction in which the hospital is located. It is equally important that cases that are not hospitalized be reported by the individual physician. It is recognized that the reporting of some of the more common childhood diseases seems of little importance to the busy practitioner. In this connection, however, we might point out that the reporting of measles has assumed a position of prominence with the curtailment of the distribution of prophylactic gamma globulin. All physicians are well aware by this time of the shortage of available gamma globulin supplies and the necessity for reporting a contact of measles or infectious hepatitis in order to obtain gamma globulin for prophylaxis or modification of the disease.

This distribution of gamma globulin for poliomyelitis contacts again stresses the value of prompt reporting. Prompt reporting of poliomyelitis cases is vital, if the Division of Com-

municable Disease Control of the State Board of Health is to maintain statistics which might qualify a community for mass immunization with gamma globulin. From all indications at the present time gamma globulin will be in short supply for several months to come. Distribution will be continued to the various states on the basis of cases of measles, infectious hepatitis, and poliomyelitis that have been reported during the calendar year 1953.

In connection with poliomyelitis cases prompt reporting is of importance to those individuals who carry so-called "Polio Insurance." The Division of Communicable Disease Control of the Indiana State Board of Health receives an inquiry concerning every claim that is presented giving poliomyelitis as a cause of illness. This information is not released to the insurance companies unless a request form has been signed by the parents or guardian of the individual named. Nevertheless, a number of these insurance claims have been held up while the necessary correspondence has been conducted to determine if a diagnosis of poliomyelitis had been made upon an individual and whether the case had been reported.

While the written report of a case of communicable disease is to be desired, it has been provided for in the regulations that the busy physician may telephone his local health officer. The continued cooperation of the physicians of Indiana in the reporting of communicable disease cases will be greatly appreciated and will enable the Division of Communicable Disease Control to render the physicians more service in the supplying of gamma globulin and statistics.

* Director, Communicable Disease Control, Indiana State Board of Health.



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In addition to relief of menopausal symptoms,
"a feeling of well-being or tonic effect" was frequently
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Estrogenic Substances (water-soluble) also known as
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*Harding, F. E.: West. J. Surg. 52:31 (Jan.) 1944.

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THE CARE OF PREMATURE INFANTS

THE FOLLOWING MATERIAL concerning the medical care of premature infants has been compiled by the Committee on Maternal and Child Health of the Indiana State Medical Association and the Division of Maternal and Child Health of the Indiana State Board of Health as part of an effort to reduce the mortality in such infants in the State of Indiana.

This article is a summary of thought at the present time, and though there may be minor differences of opinion concerning the minute details stated herein, it is felt that the total article may serve as a general guide to medical care for the premature infant. An attempt has been made to keep the material as general as possible so it may serve as a guide rather than as a formula for premature care.

This material will be printed and distributed in the near future to all hospitals in Indiana having Departments of Obstetrics (c/o Hospital Superintendent) and to the secretaries of all local medical societies. This article will be sent as well as the following material concerning premature infants:

1. "Instructions for Public Health Nurses"
2. "Instructions to Parents"
3. "Infant Formula Preparation at Home by Terminal Sterilization"

The "Instructions for Public Health Nurses" are to be used in conjunction with the home loan Gordon-Armstrong incubators which may be requested by the attending physician. A limited number of these incubators are available from the Indiana State Board of Health on request from the private physician.

Reprints of all four articles may be obtained from the Division of Maternal and Child Health of the Indiana State Board of Health, 1330 West Michigan Street, Indianapolis 7, Indiana.

Committee on Maternal and Child Health
of the Indiana State Medical Association
and Indiana State Board of Health,
Division of Maternal and Child Health

Premature Infants Medical Care

A premature infant is one that is born so early in gestation that its organs are underdeveloped, making its chance for survival less than that of a full-term infant. Any infant weighing less than 2500 grams or 5½ pounds at birth is regarded as a premature and should be handled as such even though the period of gestation has seemed to make it full-term. In Indiana in 1951 prematurity was the cause of death in one-half of all infants who died in the first year of life and two-thirds of all infants who died in the first month of life.

Premature infants suffer from a number of anatomic and physiologic handicaps resulting from the immaturity of the various systems that are not fully prepared to function until term. These handicaps will be taken up individually.

Respiration

Respiration, particularly in the very small premature, is a precarious function and the difficulties are most evident and most serious during the first few days of life. Such an infant is quite incapable of clearing his respiratory passages, and this should be done very promptly after birth before opportunity for aspiration has occurred. Sensitivity of the respiratory center in the premature is considerably less than in the full-term infant and this lack of sensitivity is made worse by the administration of excessive sedation to the mother during labor. Because of this, drugs and anesthetics given to the mother for pain relief during labor should be kept at a minimum. In addition, because of the greater fragility of the blood vessels and the easy molding of the head, intra-cranial hemor-

rhage occurs most frequently in the premature infant. Intracranial damage is likely to affect the respiratory center. To prevent any abnormal or prolonged pressure on the vault of the cranium an episiotomy should be done routinely. The use of outlet forceps in delivery is justifiable if it is felt that by their use a shorter labor and a trauma reducing result will occur.

Added to the many difficulties connected with the respiratory center is an immaturity in the lung capillaries and the elastic tissue which interferes with the expansion of the lung and the absorption of oxygen from the inspired air. These factors make the occurrence of atelectasis likely and this will lead to anoxia which will further depress the respiratory center. One should see to it that the respiratory movements are as adequate as possible, and the administration of oxygen during the early phase is of great value in reducing the incidence of serious anoxia. A further difficulty arising from the weakness and incoordination of the premature is the aspiration of food, or, more often, of vomitus. Those infants who are prone to vomit should be watched constantly so that their air passages may be cleared promptly if necessary.

For an infant that fails to breathe spontaneously, the first step is clearing the mouth and respiratory tract of mucus, then the administration of oxygen. For clearing the airway, the infant should, first of all, be placed in a warm sterile blanket. The head should be kept level with the body and turned to the side to facilitate drainage from the mouth. Lowering of the infant's head below the level of the body may be dangerous if the infant is suffering from an intracranial injury. Any accumulated mucus or secretion is removed from the mouth by drainage and by gentle aspiration. If respiration is not established, manual artificial respiration then may be attempted, as gently as possible, keeping in mind the fact that the thoracic cage is so small and the supporting tissues so soft that careless handling and traumatizing of the infant and too rapid performance of artificial respiration may do more harm than good.

If all other procedures are ineffective it may be necessary to administer oxygen under conditions of alternating negative and

positive pressure, using a resuscitator or mouth-to-mouth insufflation. The use of a resuscitator is potentially dangerous in the very small premature. When one is used, the head should be extended and the chin held up to maintain the airway.

Hanging by the feet and spanking and dunking in hot and cold water are treatments that should never be used with premature infants. The former procedure increases intracranial pressure; the latter may produce shock.

It is considered ineffective to give such drugs as alphalobeline, coramine, or metrazole to stimulate respiration. Caffeine sodium benzoate, grains $\frac{1}{4}$ to $\frac{1}{2}$ or epinephrine, 1 to 2 minims of a 1:1000 solution may be used as stimulants as necessary.

In cases in which respirations, after they are initiated, are difficult to maintain or inadequate, oxygen should be given and continued as long as indicated. A resuscitator should *not* be used when the infant is breathing spontaneously even if respirations are shallow and irregular. Most authorities advocate giving oxygen to all premature infants since the oxygen saturation of the tissues may be quite low even in the face of a good color.

Regulation of Body Temperature

The body temperature of the premature infant tends to be low, and the more immature the infant the more difficult it is to stabilize. The smaller premature is so immature that the temperature regulating mechanism depends upon the environment to maintain body temperature. Great fluctuation of body temperature can be induced merely by placing the infant in a cold or an excessively warm atmosphere. The vasomotor control is effective only to a limited extent and the premature is able to sweat slightly in a warm atmosphere. The chief features in poor heat regulation of the body are the low basal metabolic rate and the very small amount of muscular activity. This results in a limited amount of heat production. Combined with these are the relatively great body surface with the consequent tendency for rapid heat loss and the lack of insulating subcutaneous

fat. This surface area is the most important factor in the susceptibility of infants to chilling. It is for this reason that water baths should not be used since evaporation causes chilling. It is not necessary to maintain a body temperature of 98.6° but rather to supply moderate heat to maintain the temperature at a constant level between 97° and 98° . If this is done and the infant is properly cared for he will tend to stabilize his temperature at a relative low level, which will gradually become higher as he becomes more mature. It has been found that smaller prematures do better and have a more constant temperature if they can be kept in an atmosphere with a high humidity. At about 65 percent the humidity of the expired and inspired air is about the same, which helps to keep the child's temperature up and conserve fluids as well as leading to less inspissation of pulmonary contents.

An incubator that provides temperature and humidity control and the means for administering oxygen should be available.

Resistance to Infection

A newborn infant is extremely susceptible to infection, but if premature, this tendency is exaggerated. There is no known way to enhance the resistance and the situation can be handled only by meticulous care to prevent exposure of the infant to pathogenic organisms. In effect this means that the infant should be cared for in an entirely aseptic fashion. All food, bottles, equipment, linen, and clothing with which the infant is in contact should be sterilized. Sterile gowns should be worn by the attending nurse. No one with a respiratory or gastro-intestinal infection of any kind should come near the infant. The general technique should be essentially the same as is carried out in an operating room.

Hemorrhage

Increased fragility of capillaries and a prolonged clotting time in premature infants predisposes to hemorrhage. The latter is usually due to a deficiency of Vitamin K.

The mother should receive Vitamin K prior to delivery; the premature should re-

ceive injectable Vitamin K on the first and third day of life.

Anemia

The premature has to an exaggerated degree the kind of anemia which occurs to some extent in all young babies. The level of hemoglobin usually drops faster and for a longer time than in the full-term infant. This is related to a deficiency in the store of iron at birth and in addition to an immaturity of the bone marrow. Although it is an iron deficiency type of anemia it is refractory to the administration of iron until about two months of age. Because of this if anemia of a severe degree develops during this early period it can be treated only by transfusions. Quite frequently the pallor of the premature is not as great as one would expect in a patient with a low level of hemoglobin. Often the anemia will be detected only by periodic blood counts.

Digestion

The premature infant faces several nutritional handicaps in the establishment of good nutrition. The sucking and swallowing reflexes may be absent or extremely weak. The small capacity of the stomach may lead to distention and vomiting. The gastric acidity is low. The absorption of fat is poor. The digestive enzyme system is incompletely developed.

As a rule one should give the least amount of food which will result in satisfactory weight gain. Particularly during the first 24 to 48 hours the need for food is so slight that it is best withheld. During this early period the chief concern should be the establishment of satisfactory respiration and it is wise not to complicate this hazardous process by the administration of food which may be aspirated or vomited. When food is started it should be very small in amount, perhaps no more than 4 cc, and increased in amount only as the infant demonstrates an ability to retain it. The first feeding should be sterile glucose or water to minimize the dangers of aspiration. If the infant's swallowing reflex has not developed, the increases in amount are made slowly and a caloric intake of 50 calories per

pound per day should not as a rule be reached until the infant is about one week old. During the first week, under-feeding is safer than over-feeding. Since swallowing is difficult and tiring, the very small premature is fed by gavage. Usually at a weight of around 4 to 4½ pounds he may be fed satisfactorily by dropper or even by a small nipple. Infants of the same size may vary in their capacity to swallow food without undue fear of aspiration, and so long as there is any doubt about his ability, gavage feeding should be continued. In skilled hands it can be carried out with very little disturbance to the infant. The usual feeding interval is every 3 hours.

Because of the demonstrated need of prematures for a high protein intake, the formerly advocated use of breast milk is no longer tenable or desirable. Various modifications of cow's milk have been used with success. A mixture that is high in protein and carbohydrate and low in fat content is the most suitable formula. In view of the infant's limited digestibility of fats, one-half skimmed milk may be preferable to whole milk. The carbohydrate additions should usually be somewhere between 5 to 10 percent, that is, one-half to one ounce for ten ounces of milk. The premature infant tolerates carbohydrate well, and when the fat content of the feeding is low, carbohydrates may be added to provide the necessary calories.

The relatively rapid growth of the premature tends to make him very susceptible to rickets. The administration of a potent source of Vitamin D should be started within the first two weeks of life avoiding any preparation in an oil base.

At this time a concentrated form of Vitamin C should also be begun both for the prevention of scurvy and for its action in increasing the metabolism of certain amino acids from proteins.

Criteria for Discharge

Before being allowed to go home the baby should meet several requirements:

1. He should be able to maintain his own body temperature out of the incubator.

2. He should be making a satisfactory weight gain and progress on his present formula.
3. The weight gain should be steady and constant.
4. His hemoglobin should be at a satisfactory level.

Prevention of Prematurity

The prevention of premature birth involves detection and correction of abnormal conditions in the mother before and during pregnancy. The occurrence of a premature birth is less likely if the expectant mother presents herself early for prenatal care and follows closely the regimen outlined by the physician. This entails adequate rest, control of maternal infection, avoidance of heavy travel during pregnancy, maintenance of a good state of nutrition, and early detection and control of symptoms which may indicate an impending toxemia or other complication.

Summary

The proper care of premature infants must be based upon a knowledge of the facts already outlined. In summary an accepted procedure for the care of such an infant is as follows:

The prematurity of the expected infant would be known in advance and proper preparations made for its special care. The use of sedatives for the mother should be at a minimum. A warm sterile blanket should be available so that chilling immediately after birth can be avoided. The air passages should be cleared immediately. If necessary, resuscitation should be carried out and, in addition, such stimulants as adrenalin and caffeine sodium benzoate administered if required. Oxygen should be administered continuously for as long as necessary. Some type of incubator should be available. During the first 24 hours at least, food should not be administered. Excessive administration of fluids should be avoided. Parenteral fluids are seldom necessary and their administration may actually be more harmful than helpful. If the baby does well for the first day or two, food may be started in very small

amounts. If it is tolerated the amount is gradually increased. It is usually given at three hour intervals and the amount is increased until the infant is able to receive sufficient nourishment to cause satisfactory weight gain. This usually amounts to about 50 or 60 calories per pound per day. Fluid intake should be about 60-70 cc. per pound per day after the fourth or fifth day. In the case of a very small baby, gavage feeding is the best method. Extra sources of Vitamins A, D, and C should be given beginning at the second week. These vitamins are best supplied in the form of a potent concentrate. The use of drops in an oil base should be avoided because of the danger of aspiration. Anemia should be watched for, particularly from the second week to the second month of life, and if present to an important degree the infant should be transfused with 10 cc. of blood per pound of body weight. Anemia developing after the second month can usually be controlled by the administration of iron. During the whole period, particular attention should be given isolation precautions.

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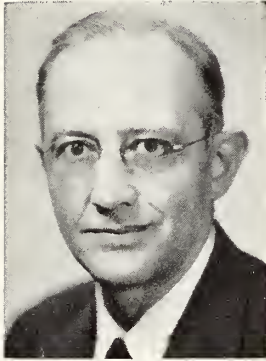
INCUBATORS APPROVED BY THE COUNCIL ON PHYSICAL MEDICINE AND REHABILITATION OF THE AMERICAN MEDICAL ASSOCIATION

September 1, 1952

1. Aloe Precision Infant Incubator, J.A.M.A. 142:1363 (April 29) 1950.
2. Armstrong X-4 (Nursery Type) Baby Incubator, Model 500. J.A.M.A. 138:24 (Sept. 4) 1948.
Manufacturer: The Gordon Armstrong Co., Inc., Cleveland.
3. Armstrong X-P Explosion-Proof Baby Incubator, Model 22. J.A.M.A. 148:553 (Feb. 16) 1952.
Manufacturer: The Gordon Armstrong Co., Inc., Cleveland.
4. Baby's Haven, Model NB5, Multipurpose Infant Unit. J.A.M.A. 147:1571 (Dec. 15) 1951.
Manufacturer: Modern Hospital Equipment, Inc., Minneapolis.
5. Isolette Infant Incubator, Model C-35. J.A.M.A. 140:677 (June 25) 1949.
Manufacturer: Air-Shields, Inc., Hatboro, Pa.



INDIANAPOLIS ATTORNEY ADDED TO LEGAL STAFF OF I. S. M. A.



Hollowell

In accordance with action of the Council, the executive committee announces the appointment of Mr. Robert Hollowell, prominent Indianapolis attorney, to the legal staff of the Indiana State Medical Association. Mr. Hollowell began his duties on October 1, 1953.

After attending both Indiana and DePauw Universities, Mr. Hollowell received his Doctor of Laws degree from the University of Michigan in 1923 and has since had a distinguished career, both in private practice and at the state government level.

A Republican, he is currently serving as Chief Counsel to Edwin K. Steers, Attorney General of Indiana. Previously he had been chief of staff to Supreme Court Judge James H. Emmert, when Judge Emmert was attorney general; Chief Counsel to former Attorney General Cleon H. Faust; and Special Counsel to former Attorney General J. Emmett McManamon.

Mr. Hollowell possesses a background of experience which will be of particular assistance to him in his new post with I.S.M.A. He recodified the state health laws as adopted by the legislature in 1949. The work was done at the direction of the Governor's committee. In 1947 Mr. Hollowell wrote the law which governed the procedure of state agencies and regulation making powers. He wrote the State Police Code and collaborated in the writing of the legal phase of hospital regulations and laws governing

communicable disease control as administered by the Indiana State Board of Health.

Teaches I. U. Course

At present Mr. Hollowell is teaching a course at the Indiana University School of Medicine, lectures on regulations concerning communicable diseases as they affect the physician, and gives three lectures on Public Health Laws.

In his private practice, Mr. Hollowell, who is licensed to practice in all state and Federal courts, represents the Indiana Pharmaceutical Association, Fidelity and Deposit Insurance Corporation of Maryland, Manufacturers Casualty Insurance Company, Standard National Indemnity, Northwestern State and Central State Banks and many other business and insurance firms.

Since 1936 he has been associated with Ralph Hamill, maintaining offices at Room 518, 8 East Market Street, Indianapolis. That association was interrupted for eight years while Judge Hamill served on the bench of Marion County Superior Court.

A native of Danville, Mr. Hollowell still lives there with Mrs. Hollowell. Their two daughters are married: Joyce to Edward Miller, a senior medical student at I. U. School of Medicine, and Janet, to John Kulka, who is with Metropolitan Life Insurance Company at East Chicago.

In addition to being a member of all the bar associations, Mr. Hollowell is a trustee of the First Methodist church, Danville, former president of the Danville College Board, member of Danville school board, president of the Girl Scout Corporation, is a member of Scottish Rite and of Sigma Chi fraternity.

Deaths

Schuyler S. Teaford, M.D., 80, Paoli physician for more than 50 years, died in Madison at King's Daughters Hospital, August 23. Death was caused by cancer and followed a long illness.

Doctor Teaford was a native of Orange County and graduate of the Hospital College of Medicine in Louisville in 1898. Prior to entering medical school he taught for several years. He established his practice in Pike County in 1898, then went to Paoli where he practiced for many years and also operated a drug store until he entered service in World War I. In addition to serving in many civic capacities, including town trustee, county health officer and as a pioneer worker and first president of the Orange County Tuberculosis Society, Doctor Teaford had been active in the Orange County Medical society having served as both president and secretary. He was a senior member of the Indiana State Medical Association.

John M. Engle, M.D., 37, general practice physician at Portland, died September 3 in Jay County Hospital two hours after suffering a coronary occlusion in his home.

A native of Winchester, Doctor Engle established his practice in Portland in 1941 after completing his internship at St. Elizabeth's Hospital, Dayton. He was a 1940 graduate of Indiana University School of Medicine. Soon after the start of World War II he enlisted in the Army Air Force Medical Corps and served for 42 months in the Pacific area with a captain's commission. He returned to Portland and had reestablished his practice, working actively in the Jay County Medical Society and in many civic endeavors. He was immediate past president of the Jay County Medical Society, and was a director of the county cancer society.

Fred H. Austin, M.D., who had practiced medicine in Bloomington for 57 years (53 years

in the same office) died September 4 in a Bloomington nursing home after an illness of two weeks. Only a few friends knew the physician-philanthropist had been in failing health. He was 83 years old.

A native of Jefferson county, Doctor Austin went to Bloomington from Madison after his graduation from the Cincinnati College of Medicine and Surgery in 1890. His career in Bloomington had been one of unusual service, both in his chosen profession, and as a citizen. He had served for many years as secretary of Monroe County Medical Society and had represented his county society as a delegate to state convention of Indiana State Medical Association of which he was a senior member. In Bloomington he had served on the city council, been an advisor to the Public Health Nursing Service and the Public Welfare department; had donated a house and lot to the Christian Center and served as a director of that activity; had furnished a site for the Salvation Army and been on its board; helped organize Boy and Girl Scout movements and sparked the erection of a center for teen-agers; founded the Exchange club in Bloomington and helped that group complete several major civic projects. In addition to his medical and civic activities, he was an active member of his church.

Emerson A. North, M.D., 73, retired psychiatrist who formerly lived in Rising Sun, died in Daytona Beach, Florida, August 21, from a heart ailment. Although a resident of Indiana for some years, Doctor North practiced in Cincinnati and retained his membership in the Ohio State Medical Association. He was a nationally known psychiatrist, was professor emeritus of psychiatry at Cincinnati College of Medicine and a member of several national psychiatric associations. Doctor North was a native of Patriot, graduate of Purdue University and the University of Cincinnati where he received his medical degree in 1906.

M. O. Robertson, M.D., 66, Bedford physician and surgeon and former medical missionary to Japan, died August 18 from injuries received in an automobile accident a few days earlier. Doctor Robertson was a native of Kentucky, graduate of the University of Louisville School of Medicine in 1911 and had been in practice in Bedford since his return from Korea in 1918. He was a member of Lawrence County Medical Society, the Indiana State and American Medical Associations.

William G. French, M.D., retired Evansville physician, died September 11. Born in 1885, Doctor French was a graduate of the Hahnemann Medical College and Hospital, Chicago, in 1906.

Ross Axe, M.D., who practiced in Hebron and Chesterton, his home town, for many years, died August 26, in Winfield, Kansas. He had been bedfast for eight years.

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News Notes

Dr. L. H. Kornafel Studies Isotopes at Oak Ridge

Lecture and laboratory instruction on the use of radioisotopes were received by Dr. L. H. Kornafel, Indianapolis, and 28 other research workers from throughout the country during a four week course conducted at the Oak Ridge Institute of Nuclear Studies.

Radioisotopes are by-products of the atomic energy process and are applicable to research in every branch of general science. The "tracer atoms" are employed in some phases of medical research and therapy and also have industrial uses.

Doctor Kornafel is interested in using radioisotopes in diagnosis and treatment of diseases of the thyroid gland.

Dr. Ernest Rupel, Indianapolis, attended the world conference on medical education held August 22-29 at the British Medical Association House, London, England.

Dr. George Pullman, who has been in general practice in Warsaw for the last year, has accepted a three year residency in radiology at Nebraska Methodist Hospital, Omaha.

Dr. Max S. Norris, who had been a member of the medical director's staff at Indiana University School of Medicine, opened an office for the practice of internal medicine

in the Hume Mansur Building, Indianapolis, in August. He is a 1949 graduate of the I. U. School of Medicine and served his internship and residency at the university hospitals. He is a veteran of World War II.

Dr. Lawrence W. Reese, who has been in practice in South Bend, has taken over the practice and office of Dr. Robert L. Witham in Culver. Doctor Reese, a graduate of the College of Medical Evangelists in Loma Linda, California, has practiced in South Bend for two years. Doctor Witham is serving a residency at I. U. Medical Center.

Walkerton has a new physician, Dr. Carl M. Ebersole, who has leased the offices and equipment of Dr. C. D. Linton. Doctor Ebersole recently completed his internship in Wadsworth Veterans Hospital, Los Angeles. He received his medical degree in 1952 from the University of Chicago. He is a naval veteran of World War II, and a native of Elkhart.

Dr. Marion F. Arnold, Jr., has been named assistant medical director of Inland Steel Company, according to an announcement by F. M. Rich, general superintendent. Doctor Arnold, who lives in East Chicago, is a graduate of I. U. School of Medicine and a native Hoosier.

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Dr. Walter H. Hollis, who has spent the last 18 months with the First Cavalry Division in Japan, has resumed his practice in Fort Branch, Gibson county.

Dr. J. Leon Simms, who has been attached to the 82nd Air Base Group of the Strategic Air Command at Lockbourne AF Base, Columbus, for the last two years, has returned to Indianapolis and resumed the private practice of medicine at 2453 Northwestern Avenue. He held the rank of captain.

Dr. Cecil M. Sennett, who has been in private practice in South Bend for many years, joined the staff of the Norman Beatty Memorial Hospital at Westville August 3. He plans to move to Westville soon.

Dr. Herman L. Hirsch has opened offices in Mount Vernon where he will practice as a physician and surgeon. A native of Poseyville, he is a graduate of St. Louis University School of Medicine and interned at St. Vincent's Hospital, Indianapolis.

Dr. Robert E. Krueger, native of Anderson and graduate of I. U. School of Medicine in 1952, has opened offices in Columbus for the general practice of medicine. He recently completed his internship at Indianapolis General Hospital. Doctor Krueger will occupy rooms formerly used by Dr. Marvin Davis who has moved to 908 Washington street, Columbus. Doctor Krueger is located at 814 Washington street.

After a two-year tour of army duty, **Dr. William W. Dalton** has resumed the practice of internal medicine at 209 Hume Mansur Building, Indianapolis. He is a 1945 graduate of I. U. School of Medicine. Twenty-two months of his service were spent in a Tokyo hospital.

Dr. Horace DeWitt Bell, who recently completed his internship at St. Joseph's Hospital, South Bend, has opened an office for the private practice of medicine at 420 North Hill street, South Bend. A native of Akron, Ohio, Doctor Bell was graduated from I. U. School of Medicine, was a faculty member at Florida A. and M. College at Tallahassee and later executive director of the Urban League at Anderson. He served 31 months in the army during World War II.

Dr. Robert C. Pronko, who has completed a one year rotating internship at Indiana University Medical Center, has joined the staff of a missionary hospital in Puerto Rico. The appointment of the former Youngstown, Ohio doctor is to Ryder Hospital, Mumacao, Puerto Rico.

Dr. Warren L. Niccum, a pediatrician, has become associated with Linvill Memorial Clinic, Columbia City, effective August 1. He was graduated from Indiana University School of Medicine in 1948, interned at Ball Memorial Hospital, Muncie, and served his residency at the University of Iowa where he was chief resident. Dr. Niccum is a native of Goshen.

COOK COUNTY GRADUATE SCHOOL OF MEDICINE

Postgraduate Courses—1953

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting October 12, October 26, November 9
Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting October 26
Surgical Anatomy & Clinical Surgery, Two Weeks, starting November 9
Gallbladder Surgery, Ten Hours, starting October 26
General Surgery, Two Weeks, starting October 12
Surgery of Colon & Rectum, One Week, starting October 26
Thoracic Surgery, One Week, starting October 12
Esophageal Surgery, One Week, starting October 19
Breast & Thyroid Surgery, One Week, starting October 26
Fractures & Traumatic Surgery, Two Weeks, starting October 26

GYNECOLOGY—Intensive Course, Two Weeks, starting October 19
Vaginal Approach to Pelvic Surgery, One Week, starting November 2

OBSTETRICS—Intensive Course, Two Weeks, starting November 2

MEDICINE—Electrocardiography & Heart Disease, Two Weeks, starting October 12
Gastroenterology, Two Weeks, starting October 26
Gastroscopy, Two Weeks, starting November 2

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Northwestern Ohio Medical Group Issues Invitation

All members of the ISMA are invited to attend a scientific session of the Northwestern Ohio Medical Association, at the Academy of Medicine, Toledo, Ohio, October 14, 1953. The program commences at 9:30 A.M. and will be concluded by 5 P.M. It will include papers by well known authorities on psychiatry, cardiac surgery, ACTH and cortisone, ovarian cancer and pediatric surgery. An informal round table discussion with the essayists will be conducted at the noon luncheon. Registration fee for members and non-members is \$10.00, which includes luncheon.

Applications for **Research Grants-in-Aid** for the fiscal year 1954-1955 must be received by American Heart Association, Inc., 44 East 23rd Street, New York 10, New York, not later than December 1, 1953. Information booklets and application blanks may be obtained from the Medical Director at the above address.

Three awards, including a cash prize of \$250, for original contributions on any phase relating to the diagnosis and treatment of chest diseases are offered by the Board of Regents of the American College of Chest Physicians. Deadline for the manuscripts is March 15, 1954. All students in accredited medical schools are eligible to compete and full details may be obtained from: Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

A postgraduate symposium on "Surgery of the Injured Hand" will be given at St. Luke's Hospital, 11311 Shaker Boulevard, Cleveland 4, Ohio, on November 5, 6, and 7. Staff doctors and other specialists from Cleveland, Philadelphia, Chicago, Cincinnati and Nashville, Tennessee, will participate in the symposium.

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Doctors Named to Health Office Vacancies

In Winchester, Dr. Howard William Koch, who has just begun practice there, has been named Randolph county health officer to succeed Dr. B. F. Wills, Union City.

Dr. Robert Boze, who is now occupying former offices of Dr. M. L. Habegger, has been named to succeed Doctor Habegger as a member of the Berne city board of health.

At Garrett, DeKalb county commissioners recently named Dr. R. Perry Reynolds county coroner. He had been deputy coroner and succeeds Dr. C. B. Hathaway, Butler, who resigned because of illness.

Dr. Robert B. Miller, graduate of Indiana University School of Medicine, has opened offices in Fort Wayne, Room 714, Medical Center Building, where he will specialize in ear, nose and throat. He is certified by the American Board of Otolaryngology. Doctor Miller has been in private practice in Detroit for four years. He served as a flight surgeon in World War II.

As of September 1, Dr. Jess E. Burks resumed his practice in Crawfordsville where he had been for more than five years previous to his recall to duty as a flight surgeon at Clovis Air Force Base, New Mexico. He served just six months after being recalled. His offices are at Room 441, Ben Hur Building, Crawfordsville.

Union City has completed arrangements to obtain two new doctors for the community according to Vern Ramsey, president of the Chamber of Commerce. Dr. William Wagner, native of Butler and graduate of I. U. School of Medicine, will soon move into offices vacated in September by Dr. B. F. Wills who moved to Indianapolis. Doctor Wagner has been in military service 12 years. Dr. Harold Rothermel, who interned at St. Rita's Hospital, Lima, and has been practicing in Botkins, Ohio, opened an office at 312 North Columbia street August 24. He is a former resident of Whitewater and a graduate of University of Cincinnati College of Medicine.

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Dr. Alan Willner, who has practiced in Clarksville for four years, left September 8 for two years duty with the U. S. Army. He reported to San Antonio, Texas. During his absence Dr. George M. Wolverton, formerly of Indianapolis and Noblesville, will take care of his practice. The two doctors will remain in practice together following Doctor Willner's return. Doctor Wolverton is an I. U. graduate, had two years resident training at Cook County Hospital, Chicago, and has just been released after serving two years in the U. S. Navy.

Dr. Edward H. Carleton, Dyer, has been named general medical director of Inland Steel Company. He has been director of the medical department of Inland's Indiana Harbor Works. Doctor Carleton is a past president of the Industrial Medical Association and is now serving as chairman of the health committee of American Iron and Steel Institute.

His appointment as medical officer in charge of the Pennsylvania Railroad's medical program at Terre Haute and Bicknell, Decatur and East St. Louis, Illinois and St. Louis, brought **Dr. Cyril E. McEnany** to Terre Haute where his headquarters were established September 1. A native Iowan, Dr. McEnany joined the railroad's medical department last May following his retirement as a colonel in the U. S. Army Medical Corps. He will administer a "maintenance-of-health" program for employes which is designed to supplement the care they receive from their family physicians.

Approximately 190 members of Lake County Medical Society held their annual outing at Lake Hills Country club August 12. Golf, games, a picnic, dinner and a show furnished entertainment throughout the day.

Dr. Robert R. Acre and **Dr. Daniel M. Hare**, Evansville urologists, have moved from 617 Hulman Building to their new office building at 706 Walnut street, Evansville.

Dr. George O. Avery recently opened an office for the practice of medicine at 2117 West Washington street, Indianapolis. He is a graduate of I. U. School of Medicine, interned at Methodist Hospital, Indianapolis, and served two years in the army.

Dr. John R. Gill, graduate of University of Colorado School of Medicine, is now associated with Dr. C. R. Bjorklund at Hobart in the practice of medicine and surgery. Doctor Gill interned at Methodist Hospital, Gary.

Rockport's newest doctor is **Dr. Michael Monar**, Indianapolis, who opened his offices September 3 in rooms recently vacated by Dr. William Kerrigan, who has moved to California. Dr. Monar is an I. U. School of Medicine graduate and was recently discharged from service after serving as a captain in the medical corps in Japan and Korea.

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A. M. A. Washington Office News

Dr. Casberg's Office Reassures Draft-Eligibles: The office of Dr. Melvin Casberg, Assistant Secretary of Defense for Medical Matters, reassures those draft-eligible doctors alerted by Selective Service but not actually ordered to duty that they may have more time than they think. A spokesman for Dr. Casberg emphasized that there often is a long delay between receipt of individual letters informing the physicians they will be called and their actual orders carrying the date to report. Most of the men involved want to postpone closing out their practice or making other personal arrangements until they receive more definite word as to when they must leave civilian life. That definite word, according to the Assistant Secretary's office, comes with the orders which specify a particular date. A minimum of 30 days is provided between receipt of the order and the date for reporting for duty. In many cases, a much longer period is allowed.

Doctor Draft Directive Due by September 1. Defense Department's directive on the new doctor draft law is expected to be issued about September 1. It has been in preparation since June 29 when the new law was signed by President Eisenhower. The document, with which the three services will be expected to conform, currently is being reviewed by personnel officers of the three services and by Selective Service prior to its release. The services currently are making their separate interpretations of provisions of the new law.

New Revenue Legislation Being Drawn Up: Jenkins-Keogh Uncertain. Following completion of hearings, the House Ways and Means Committee staff, in cooperation with the Joint Committee on Internal Revenue Taxation, has started reviewing the whole complicated problem of revising the income tax laws. Although there are no plans to reassemble either committee prior to reconvening of Congress, the staffs expect to have a report and legislation ready by the first of the year.

At this stage it is not known whether the proposed bill will include the Jenkins-Keogh plan for allowing self-employed persons to defer income tax payments on money put into retirement funds. One staff member said that if this suggestion is recommended at all it probably will be in a separate bill. One obstacle to favorable committee consideration is the unchanged position of the Treasury, which is expected to inform the committee staff shortly that it still objects to the Jenkins-Keogh principle.

Defense Department Starts Draft of Dependent Care Bill. A Defense Department committee, including representatives from the three military medical services, has started preliminary work on legislation to implement recommendations of the Commission on Dependent Care. The department's legal staff and its comptroller general's office also are assisting in the work, which is being carried out under supervision of Dr. Melvin A. Casberg, Assistant Secretary for Health and Medical Matters.

The department hopes to have a bill ready for presentation when Congress reconvenes in January or shortly thereafter. It is expected that representatives from American Medical Association and other affected professional groups will be called in for advice after the committee has made some progress.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION EXECUTIVE COMMITTEE

August 30, 1953

Meeting called to order at 11:00 a.m.

Roll call showed the following present: W. L. Portteus, M.D., chairman; James W. Denny, M.D.; Paul D. Crimm, M.D.; Roy V. Myers, M.D.

Albert Stump, attorney; James A. Waggener, executive secretary, and Robert J. Amick, field secretary.

Membership Report

Number of members August 28, 1953	3,759*
Number of members August 28, 1952	3,672
Gain over last year	87
Number of members December 31, 1952	3,783

* Includes 143 in military service (gratis)

109—\$10.00 members (residents and interns)

249—senior members

75—members, dues remitted by Council

Number who have paid AMA dues:

1951	2,997
1952	3,569
1953	3,149

Headquarters Office

The field secretary reported on his activities during the previous month, stating that he was contacting members of the State Legislature and completing the survey of the welfare situation and contacting new physicians. He also reported on the attitude of some of the societies with regard to the proposed diabetes detection drive, and upon motion of Drs. Myers and Crimm, the committee voted that the Council be requested to urge all physicians to participate in the diabetes detection drive as a good public relations gesture.

Legislative Matters

National

The secretary reported on the clipping which appeared in The Indianapolis News on August 26 in which it was stated that Representative Langer proposed a Congressional investigation of the VA for denying veterans chiropractic care. The clipping also stated that Representative Langer is presently a patient at the Spears Chiropractic Sanitarium at Denver, Colorado.

Local

A letter from the Attorney General relative to the waiver of delinquent and penalty fees for returning veteran physicians was read.

1953 Annual Convention, French Lick,
October 19, 20 and 21, 1953:

Scientific exhibit. The secretary's request for placement of the scientific exhibit on the mezzanine floor with the technical exhibit was approved by consent.

The convention program was noted and accepted.

Dr. Carl H. McCaskey is to look after the seating of the wives of those at the speakers' table, the past presidents and the councilors and their wives.

Organization Matters

Letter read from the Judicial Council of the American Medical Association and upon motion of Drs. Crimm and Denny the matter was referred to the Legislative Committee, with the comment that the Executive Committee did not approve or disapprove of the Illinois resolution, but merely requested clarification, it being the feeling of the committee that it would be wise for the Judicial Council of the A. M. A. to clarify the points in question in the Principles of Medical Ethics.

A letter from the Indiana State Board of Medical Registration and Examination, addressed to Wemple Dodds, M.D., chairman of the Council committee regarding the recognition of diplomates of the National Board, was read and discussed, no action being taken.

The annual report of the Executive Committee to the House of Delegates was approved, with the following additions, upon motion of Drs. Myers and Denny:

- a. In the membership report, a similar report to be made showing the status of A. M. A. membership in Indiana.
- b. Some history regarding the St. Paul Mercury Indemnity Company to be included, along with the fact that this company is the Association-approved carrier for malpractice insurance.

Constitution and By-Laws. The secretary called the attention of the committee to several matters regarding the Constitution and By-Laws of the association, and upon motion of Drs. Denny and Myers the secretary was instructed to call these to the attention of the standing Committee on Constitution and By-Laws.

"Physician of the Year" award. Upon motion of Drs. Denny and Myers the executive secretary was instructed to send the following memorandum to members of the Council of the association and to arrange a telephone conference for Friday, Sep-

tember 4, at 3:00 p.m. between members of the Executive Committee and the Council for the purpose of discussing and settling the matter of the award for the "Physician of the Year":

"RULES FOR SELECTION OF PHYSICIAN OF THE YEAR"

"The following memorandum was dictated by the Executive Committee to the executive secretary for distribution to officers and councilors of the Indiana State Medical Association, and was approved upon motion duly made and seconded:

"The Executive Committee, at its meeting on August 30, had before it the memorandum sent officers and members of the Council of the Association under date of August 25, setting forth the proposed rules governing selection of the 'Physician of the Year' by the Association as reported by the special committee of the Council.

"The Executive Committee desires to call to your attention that the rules as proposed defeat the intent of the proposal made by the Executive Committee to the Council at its meeting on July 19.

"You will recall in the presentation of the matters referred to the Council by the Executive Committee, we specifically requested that the rules be amended, or expanded, so as to permit the awarding of this recognition to ANY physician member of the Association, who in the minds of his colleagues had made an outstanding contribution to the cause of medicine. It was further pointed out that the method which we have followed in the past has not encouraged consideration of younger men who might have performed some service of outstanding merit and worthy of recognition by the profession. In fact, some of our societies have reported that unless the scope of this award is broadened they are not the least interested in participating in the program.

"It was not the intent of the Executive Committee to exclude a member because of his age, neither was it our intent to see younger men excluded, nor was it our intention to have other than General Practitioners ineligible for the award if their performance merited special recognition.

"It was and still is our feeling that this award on behalf of our Association should more nearly reflect the spirit in which it was made, and that it should be for outstanding public service in the practice of medicine, whether he be a General man or a specialist. It would appear to this committee that an award based on this premise would be of much greater public relations value and encourage all physicians to do their best in carrying on their daily practice.

"It was the impression of the Executive Commit-

tee that the Council concurred in our thinking, the only delay being the formation of rules or conditions for the award which might be forwarded to the component societies and thereby encourage better participation on their part in this particular program.

"The rules as submitted do not in our opinion reflect the opinion as expressed by the Council, and we therefore urge that the rules as submitted be not adopted.

"It would appear that the rules could be simple, and short, and something similar to the following:

'RULES FOR PHYSICIAN OF THE YEAR AWARD

'The physician shall be an active practitioner of medicine in Indiana who has done outstanding work in his respective field and shall be a member of the Indiana State Medical Association.'

"The balance of the rules, beginning with paragraph 'd', Section I, meet with our approval.

"We have instructed the executive secretary to arrange a telephone conference hookup at 3:00 p.m., daylight saving time, Friday, September 4, for the purpose of discussing this with you over the 'phone. On this conference hookup it is planned to have all councilors and members of the Executive Committee on the line so all may participate in the discussion and this matter may be settled in time to notify the societies and so a definite order may be placed with the manufacturer of the plaques.

"Sample wording which we propose to place on the plaque follows:

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PHYSICIAN OF THE YEAR

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FAITHFUL SERVICE TO HUMANITY."

Woman's Auxiliary meeting. The request of the Woman's Auxiliary for a policy meeting with the

Executive Committee was brought to the attention of the committee and the hour of 12:30, Sunday, September 13, 1953, was established as the time for such a meeting.

Future Meetings

Michigan State meeting, September 21 and 22. Dr. Howard and the executive secretary to attend.

Kentucky State meeting, September 24. Dr. Crimm and executive secretary to attend.

Indiana State Nurses' Association, October 2, Fort Wayne. Dr. Howard and the executive secretary are to attend.

Wisconsin State meeting, October 5 to 8. Dr. Crimm and the executive secretary are to attend.

State Medical Journal conference, Chicago, November 9 and 10. Dr. Ramsey, Mrs. Grover and the executive secretary are to attend.

A. M. A. Clinical session, St. Louis, December 1 to 4, 1953. By consent permission was granted for the field secretary to attend this meeting.

New Business

The secretary was requested to procure information on the student loan fund as it is operated by the Tennessee State Medical Association.

There being no further business, the committee adjourned to meet again at 11:00 a.m., Sunday, September 13, 1953, at the Columbia Club, Indianapolis.

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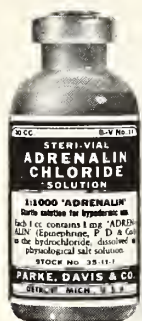
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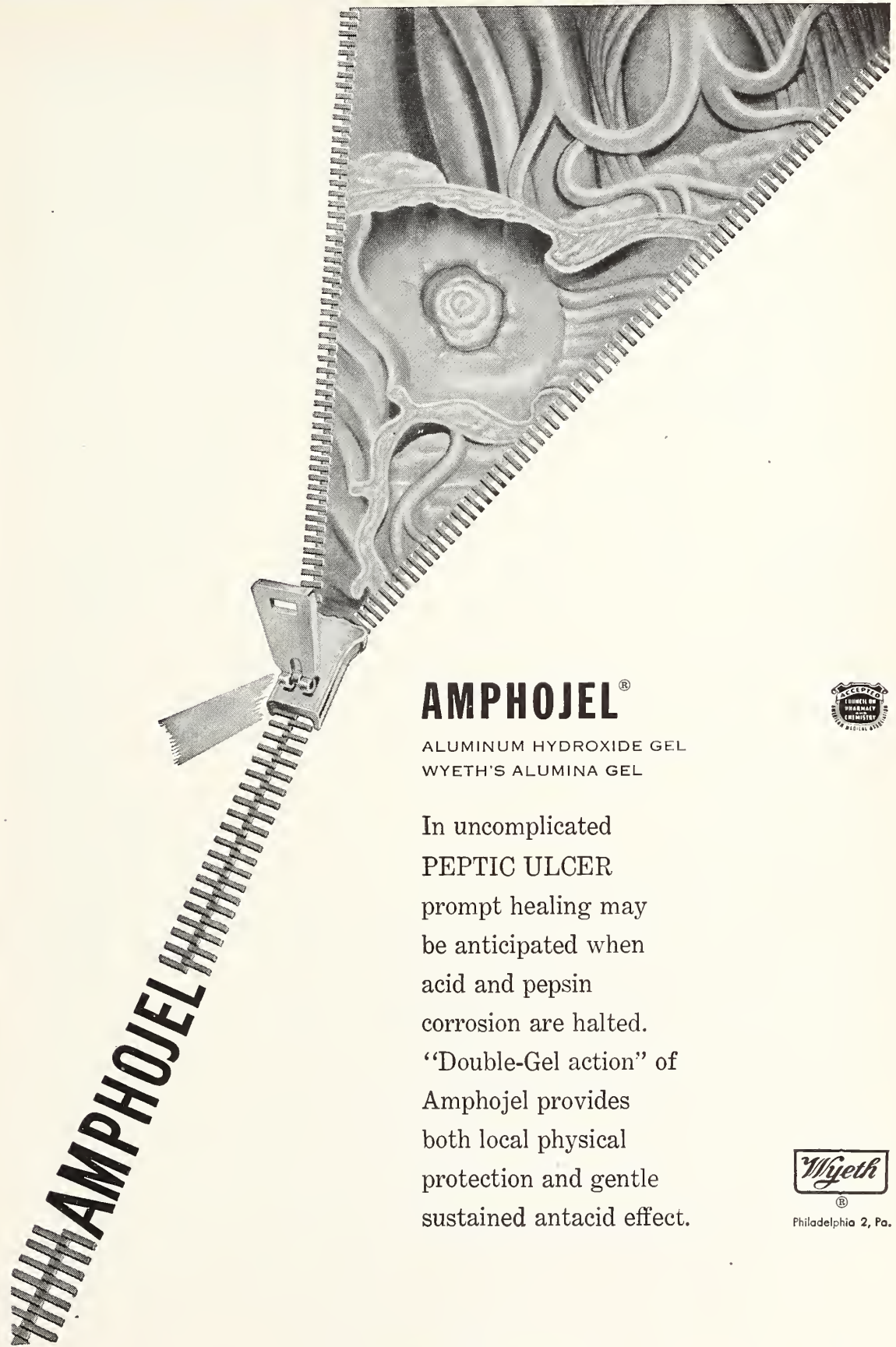
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4.	Joseph M. Black, M.D., Seymour.....	Clifford A. Wiethoff, M.D., Seymour.....	Seymour, May 5, 1954
5.	Stuart R. Combs, M.D., Terre Haute.....	C. M. Schauwecker, M.D., Greencastle.....	Terre Haute, May 19, 1954
6.	Robert W. Kuhn, M.D., Wilkinson.....	W. R. Tindall, M.D.....	Shelbyville
7.	Ralph V. Everly, M.D., Indianapolis.....	T. V. Petranoff, M.D., Indianapolis.....	Indianapolis, May, 1954
8.	Arvin Henderson, M.D., Ridgeville.....	Paul W. Sparks, M.D., Winchester.....	
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12.	James M. Burk, M.D., Decatur.....	J. L. Eisaman, M.D., Bluffton.....	
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At the Eighteenth Annual Convocation, Canadian and United States Sections, International College of Surgeons, which was held in Carnegie Hall, New York, September 17, the following Indiana surgeons became Qualified Fellows: Dr. Thomas D. Armstrong, Michigan City; Dr. Richard Rowland Hughes, Lafayette; Dr. Elvin Lee Fitzsimmons, Evansville; Dr. Milton Bernard Gevirtz, Hammond; Dr. Ivan Gilbert, Terre Haute; and Dr. Norman Frederic Richard, Shelbyville.

Among those who became Associates were Dr. Earl W. Bailey, Logansport; Dr. Edward Richard Cotter, East Chicago; Dr. William Harry Hutto, Kokomo; and Dr. Victor Paul Slepikas, Edinburg.

Dr. George J. Garceau, Indianapolis, is a member of the Board of Regents of the U. S. Section, International College of Surgeons.

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500 DOCTORS DUE FOR TRANSFER FROM ARMY TO NAVY AND AIR FORCE

REDISTRIBUTION to the Navy and Air Force of approximately 500 volunteer doctors recently commissioned in the Army is being undertaken, the Department of Defense has announced.

The rather large number of available volunteers is due to the number of physicians who shortly after the Doctor Draft Act was extended for an additional two years, and after the August draft call was announced, decided to volunteer for service now rather than wait until called by their draft boards, Defense Department officials point out.

An additional reason cited by the Department is that many of the doctors now on duty in the Army, who are entitled to early release under the new Doctor Draft Act, are not taking advantage of this opportunity. A sharp decrease in the number of physicians being granted deferments for additional professional training also contributes to the present situation.

The Navy and Air Force recently have not been accepting volunteers since both of these services temporarily had a number of physicians adequate to meet their needs. Because of scheduled losses, however, these services are now in a position to use some of the Army's volunteers.

Insofar as possible, the redistribution will be accomplished by voluntary interservice transfer; that is, by transferring the commissions of the doctors concerned from the Army to the Navy and Air Force. However, if the number of physicians desiring inter-service transfer is insufficient, then it may be necessary to detail some Army doctors to duty with the Navy and Air Force, the Department of Defense points out.

No further draft calls for physicians will be made and no more volunteer medical officers accepted until such time as losses create new vacancies.



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Medical Panorama—

A. W. Cavins, M. D.

Associate Editor

HAS THE OLD ORDER CHANGED?

The following editorial from the *North Carolina Medical Journal*, August 1953, speaks for itself and also speaks for a host of physicians. This thought has occurred to us, too, but we have lacked the words to pin it to paper as it is below:

"WATCH IT, DOC"

An editorial in the *Journal of the American Medical Association* for July 18 is a clear and forceful answer to the scurrilous attack upon the medical profession in *Life* magazine for June 22—"Watch It, Doc." Since most of the readers of the JOURNAL also get the J.A.M.A., it is not necessary to quote more than the concluding statement of this reply to *Life*: "In reporting on the A.M.A. action, *Life* threw the fundamental canons of journalism—sincerity, truthfulness, and accuracy—out of the window. In doing so, *Life* betrayed not only the physicians of this country but also its big family of readers."

This JOURNAL has a further criticism and another bone to pick with the writer of the *Life* editorial, and that concerns its title, "Watch It, Doc." It is hard to conceive of a term better calculated to arouse the ire of the average self-respecting physician than "Doc."

When the late Dr. David Riesman, one of the kindest and most courteous men who ever lived, was making rounds in the old Polyclinic Hospital in Philadelphia, a ward patient thoughtlessly called him "Doc." Drawing himself up to his full height of 5 feet, 7 inches, Dr. Riesman rebuked the patient in chilling tones: "Doctor, if you please! We are all doctors here." The late Dr. J. K. Pepper of Winston-Salem often said that nobody but ignorant Negroes and poor white trash called a physician "Doc."

Although it is half a century since Owen Wister's novel, "The Virginian," was published, the hero's warning to the villain, when the latter called him by a name reflecting upon his mother, is still current: "When you call me that, smile." While occasionally a physician's intimate friend may call him "Doc" as a term of affection, the appellation should always be accompanied by a smile. Certainly the editor of *Life* was not smiling when he added to the injury of a false and damaging charge against the medical profession the insult of using the term that most doctors detest above all others.

Not too many years ago, no self-respecting editor of a reputable magazine would have used such an opprobrious, smart aleck title. But "the old order changeth, yielding place to new." Have we already yielded? Not in North Carolina!



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Indiana Doctors on ACS Chicago Forums

Several members of the faculty of the Indiana University School of Medicine participated in the 39th Clinical Congress of the American College of Surgeons held October 5 to 9 in Chicago.

Dr. Harris B. Shumacker, Jr., chairman of the Department of Surgery at the school, was a member of the committee arranging the Forums on Fundamental Surgical Problems; served as moderator for the postgraduate course panel on "Aneurysms and Arteriovenous Fistula" in the section on cardiovascular surgery; presided at the forum on "Lungs and Peripheral Circulation"; and participated in the panel on "Cardiodynamics of Experimental Septal Defects in Dogs" which was part of the forum on "Heart and Great Vessels."

Others taking part in that forum were Drs. Harold King, Warren Coggeshall and Paul R. Lurie, of the Department of Surgery and Pediatrics at I. U.

Dr. Gerald W. Gustafson, professor of ob-

stetrics and gynecology, participated in two panels, one on "Management and Problems of Prolonged Labor" and the other on "Abortion". He discussed "Septic Abortion".

Dr. J. Stanley Battersby of the I. U. Department of Surgery, presented a paper on "Esophageal Replacement by Use of the Right Colon, A One-Stage Thoraco-abdominal Procedure, an Experimental and Clinical Study". Dr. Battersby's paper was part of the forum on the gastrointestinal tract.

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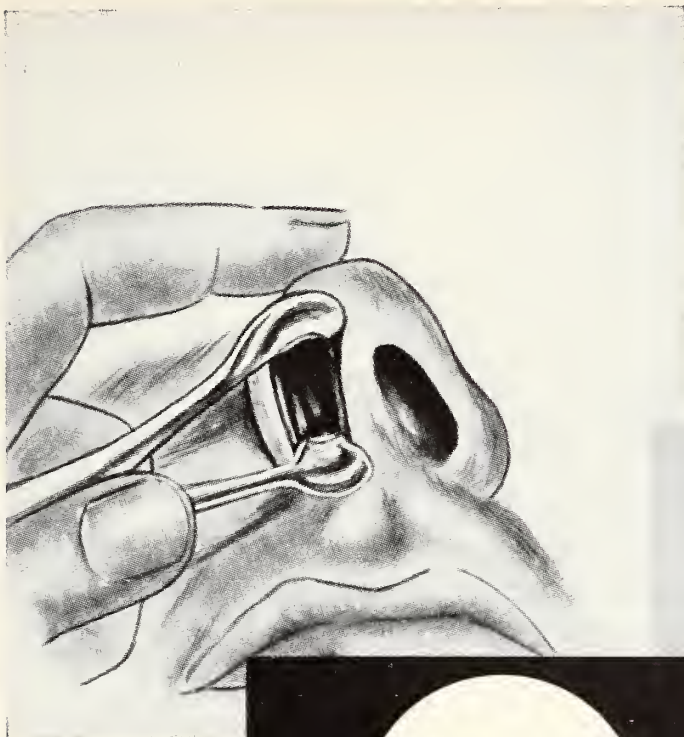
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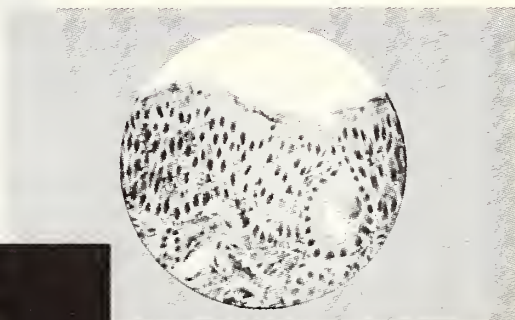


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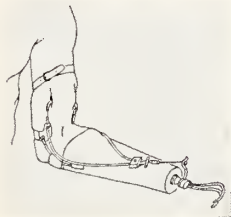


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Letters to the Editor

Note: The following letter was received from Mac F. Cahal, executive secretary of The American Academy of General Practice, Broadway at 34th Street, Kansas City 11, Missouri.*

September 23, 1953

Dear Dr. Ramsey:

I try to give a quick glance to all the state, county and national medical journals which come through our office. Seldom do I find time for more than a cursory glance, but when I ran upon the August issue of your estimable journal, I paused for a good long examination.

My heartiest congratulations to you on what I regard as the best effort yet to devote a special issue of a state journal to the general practitioner.

Not only is it a fine job of publishing; I feel sure your editorial accomplishment will be lauded by all general practitioners in Indiana, whether they be members of the American Academy of General Practice or not.

Sincerely
Mac F. Cahal

mfc:gdr

*The Journal staff is glad to have this opportunity to again acknowledge the enthusiastic and able work which was done by the officers and committeemen of the Section on General Practice of the State Association in preparing the General Practice Issue for 1953.

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Letters to the Editor

State of Indiana
Department of Civil Defense
777 North Meridian Street
Indianapolis

September 22, 1953

Frank B. Ramsey, M.D.,
Editor,
The Journal of the
Indiana State Medical Assn.
1017 Hume Mansur Bldg.
23 E. Ohio
Indianapolis, Indiana

Dear Doctor Ramsey:

Thank you for allowing me to read the fine editorial on civil defense that you have prepared for the Indiana State Medical Association Journal.

I have perused it and am pleased that you plan to give civil defense this needed stimulus by printing this editorial.

As you suggested a few deletions were made and one page was added on county organization. I couldn't resist this opportunity to mention the fact that target cities medical people will not be able to handle an atomic bombing by themselves.

As you know from your experiences working with Dr. Hahn here in Indianapolis, the citizens of all walks of life have been rather slow in assuming their responsibility for mobile and fixed installation support.

However, if you consider my additions unnecessary or too lengthy, I certainly don't object to you deleting them.

Again may I thank you for this excellent stimulation to the medical civil defense program.

Sincerely,
Frederick T. Cretors
State Civil Defense Director

FTC/sr
Encl: 2

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WIDESPREAD INTEREST SHOWN BY DOCTORS IN INDIANA LOCATIONS

PUBLICATION of the story on the Physician Placement Service of the Indiana State Medical Association in *THE JOURNAL* of I.S.M.A. and subsequently in national medical publications has brought an increased number of requests from out-of-state doctors for the brochure "A Place of Your Own Is Awaiting You in Indiana".

Three Indiana communities needing doctors have added their names to the lists previously published in *THE JOURNAL*. They are:



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LEESBURG—Kosciusko county; population 425; located in lake region. Contact P. M. Bridenthall, Township Trustee, Leesburg, Indiana.

WINAMAC—county seat of Pulaski county; population 1,835. Good agricultural community. Contact E. C. Gorrell, editor, Pulaski County Democrat, Winamac, Indiana.

Doctors who have inquired about openings in Indiana include:

Andrew G. Reitwiesner, M.D., 45 Grandview Avenue, Mount Vernon, New York.

Philip K. Wiley, M.D., c/o Dr. C. B. Hathaway, Butler, Indiana.

Robert D. Murphy, M.D., Evangelical Deaconess Hospital, 6150 Oakland Avenue, St. Louis, Missouri. Wants general practice; available July, 1954.

Gilbert B. Bluhm, M.D., 1309 Tippecanoe, Lafayette, Indiana. General practice, available July, 1954.

Wayne F. Spenader, M.D., Williamsport Hospital, Williamsport, Pennsylvania. General practice, available January 1954.

Robert L. Tentler, M.D., VA Hospital, Dearborn, Michigan. Internal medicine, available August 1, 1954.

(Continued on Page 1140)

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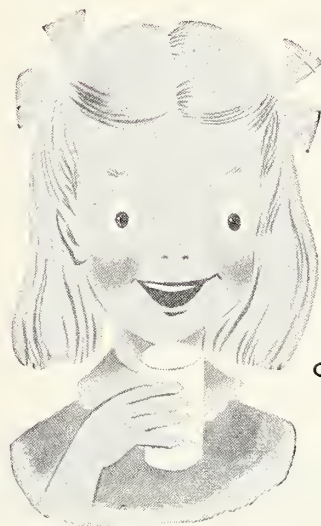
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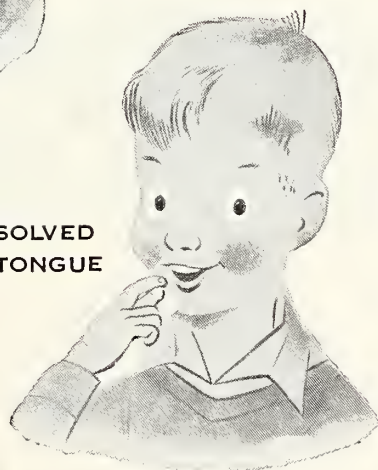


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WIDESPREAD INTEREST SHOWN BY DOCTORS (Cont.)

Margaret Cinquegrana, M.D., 1683 Fall River Avenue, Seekonk, Massachusetts.

Bernard I. Levatin, M.D., 711 Odd Fellows Building, South Bend, Indiana.

J. Howard Johnston, M.D., 107 Dauntless Lane, Hartford 5, Connecticut. General practice and industrial.

Emil W. Mozola, M.D., 2624 Noble Road, Cleveland Heights 21, Ohio.

Richard Wagner, M.D., 458 Clinton, Frankfort, Indiana. General practice.

Joseph A. Miller, M.D., 4634 Pleasant Run Parkway, N. D., Indianapolis, Indiana. General practice.

James A. Schuler, M.D., Rodriques Army Hospital, San Juan, Puerto Rico. Obstetrics and gynecology; available July, 1954.

Lloyd R. Wagner, M.D., Leigh, Nebraska. Associate.

Noah M. Dixon, Jr., M.D., 1691 Glynn Court, Detroit 6, Michigan. Internal medicine.

B. D. Bichacoff, M.D., 615 West Wayne Street, Fort Wayne 2, Indiana.

M. J. Fujawa, M.D., St Joseph Hospital, 215 West Fourth Street, Mishawaka, Indiana.

Floyd L. Rheinheimer, M.D., 750 North Tibbs Avenue, Indianapolis, Indiana.

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AMA President Speaker at Crippled Children Session

Among the distinguished authorities who will appear as speakers at the November 12-14 annual convention of the National Society for Crippled Children and Adults in Chicago's Palmer House will be Dr. Edward J. McCormick, Toledo, president of the American Medical Association. Dr. McCormick has served as AMA counselor to the National Society for four years.

Others on the program include Dr. Frances R. Horwich, Chicago, the "Miss Frances" of television fame who will be principal speaker at the parents' institute; Dr. Henry H. Kessler, West Orange, New Jersey, national authority on rehabilitation; and Dr. William T. Sanger, president of the National Society for Crippled Children and Adults.

A number of handicapped persons will form a panel to discuss means of outwitting physical problems.

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THE Indiana University Medical Center Library is expanding its reference and loan services. All physicians in the state are invited to make use of the facilities of the Library.

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Requests for the loan of specific books and periodicals will also be filled. When making such a request please include the following complete information:

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- 2) Periodicals—author of article, title of article, inclusive pagination, title of journal, volume, and date.

Regulations Governing Loaning and Mailing

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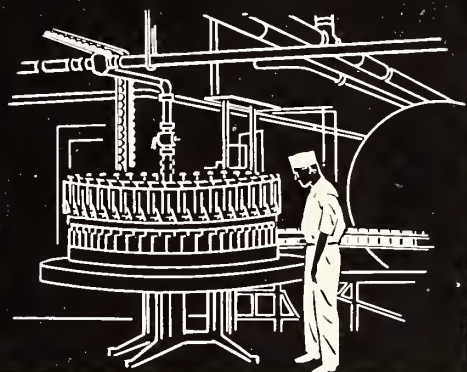
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*Cheadle—Artificial Feeding and Food Disorders of Infants, Sixth Edition (1906)

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SURVEY SHOWS RECORD GAIN IN PERSONS VOLUNTARILY INSURED

THE AMERICAN PEOPLE voluntarily increased their protection against the unexpected costs of hospital, surgical and medical care to new record high levels in 1952, the Health Insurance Council has reported in its annual survey of accident and health coverage in the United States. Every section of the country participated in the gains, the Council said.

Indiana contributed to this record with 2,638,000 persons in the state protected against the expense of hospitalization at the end of last year, 2,460,000 against surgical expense, and 877,000 against medical expense.

Cash benefits flowing from voluntary health protection aggregated more than \$2 billions nationally in 1952, the Council stated in its first public estimate of these figures. About half this amount went to help meet the cost of hospitalization, and over a half billion dollars more went towards operations and doctors' bills. Another half billion dollars represented benefit

payments by insurance companies replacing income lost due to accident or sickness. Thus voluntary health protection is now taking care of a substantial part of the nation's health bill, the Council stated.

The total number of persons covered against hospital expense approached the 92-million mark at the end of last year, the Council reported. This represented an increase of more than 5½ million, or 7 percent, over 1951.

More than 73 million persons were protected against the cost of operations under surgical expense coverage at the end of 1952, the Council said. This figure represented an increase of more than 7½ million persons, or 12 percent, over the year before.

Approximately 8 million more persons than in 1951 were protected against doctors' bills under medical expense coverage at the end of last year, the Council stated. This increase

(Continued on Page 1146)

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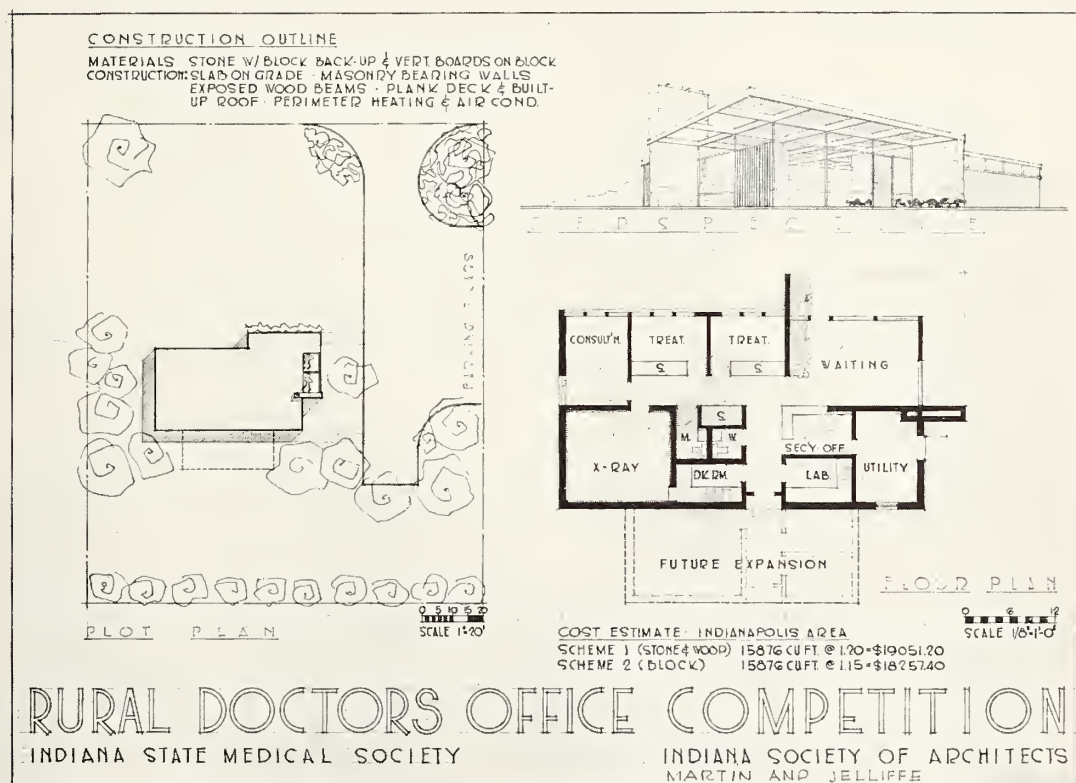
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PLAN FOR RURAL DOCTOR'S OFFICE HAS ROOM FOR EXPANSION, PARKING



Another of the five designs selected by a five-man jury in the contest sponsored jointly by the Indiana Society of Architects and the Indiana State Medical Association is presented here. The first plan was published in the September Journal.

Martin and Jelliffe, Indianapolis architects with offices at 6100 Millersville Road, submitted the plan illustrated. They suggest a choice of two construction schemes, one of stone and wood and one of block.

The design calls for perimeter heating and air conditioning. In addition to the waiting room, a consultation room, two treatment rooms, X-ray room, laboratory, dark room, secretary's office, utility room and two restrooms are provided.

Cost estimates were furnished for the Indianapolis area only. The stone and wood plan was figured at \$19,051.20; the block construction at \$18,257.40. Cost of construction in smaller communities might be appreciably lower.

Members of the firm submitting the design are John H. Jelliffe and Wesley P. Martin.

SURVEY SHOWS RECORD GAIN IN VOLUNTARILY INSURED (Cont.)

brought the total number of persons so protected to nearly 36 million and represented an increase of 29 percent over 1951.

The number of persons protected against loss of income due to disability exceeded 38 million at the end of last year, a new high mark, the Council stated.

The year likewise saw increasing public acceptance of major-medical expense coverage, the newest form of voluntary health protection designed to help meet the catastrophic costs of very serious illness. Nearly 700,000 persons had this form of protection at the end of last year, the Council stated.

Broadly speaking, major-medical expense coverage takes up where the customary forms of health protection—hospital, surgical and medical care—leave off. It provides maximum benefits ranging from \$2,500 to \$10,000. This maximum may apply to any one illness, to any one family member, or to the total payable in any one year. To keep the cost of this protection down, major-

medical expense coverage is written with a deductible feature, as is automobile collision insurance. Likewise, through co-insurance, it makes the person protected responsible for a share of the costs of care above the deductible amount, thus encouraging the use of only such health services as are really needed.

"The development of major-medical expense coverage," the Council stated in its report, "is further evidence of the willingness of the insurance business to experiment in the public interest and to take steps to meet a recognized public need. It testifies to the alertness of the companies writing accident and health protection in recognizing the need for broader coverage than had heretofore been available, and thus reflects the inherent vitality of the voluntary health movement in this country."

Organizations covered in the Council report include insurance companies, Blue Cross, Blue Shield and various other independent plans sponsored by business and industry, employee benefit associations, and private group clinics.

The Council is an organization of nine associations in the insurance business made up of companies writing the various forms of protection against hospital and medical costs and the loss of income due to disability. Its members are: American Life Convention, American Mutual Alliance, Association of Casualty and Surety Companies, Association of Life Insurance Medical Directors, Bureau of Accident and Health Underwriters, Health and Accident Underwriters Conference, International Claim Association, Life Insurance Association of America, and Life Insurers Conference.

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Opinions From Here and There

Prepared for your information by the Committee on Public Policy and
Legislation of the Indiana State Medical Association

Congressional Activity in Brief

During the period January 3 to August 3, 1953 (first session of the 83rd Congress), 10,695 legislative measures were introduced in the House and Senate. All of these were carefully screened for medical significance. Two hundred seventy-four measures were determined to be of interest to the medical profession. This total exceeds by 24 medical measures in the entire 2-year period of the 82nd Congress.

Health measures enacted into law were (8):

- S. 106—Commission on Organization of the Executive Branch—Became *Public Law 108*.
- S. 1514—Commission on Intergovernmental Relations—Became *Public Law 109*.
- S. 967—Two-year extension of Hill-Burton Act—Became *Public Law 151*.
- S. 1515—Compact between certain western states and U.S. territories to promote higher education—Became *Public Law 226*.
- H.R. 4495—Doctor Draft Act—Became *Public Law 84*.
- H.R. 5636—To establish a 3-year presumption of service-connection for all types of tuberculosis—Became *Public Law 241*.
- H.R. 5740—Factory Inspections by Food and Drug Agents—Became *Public Law 217*.
- H.J. Res. 223—Making reorganization of FSA effective within ten days—Became *Public Law 13*.

This session of Congress has taken no action on the following subjects that were of concern in former sessions: national compulsory health insurance, federal assistance for medical education, provision of school health services through federal subsidization, federal assistance in establishing and maintaining local public health departments, and provisions of emergency maternity and infant care (EMIC) for families of servicemen. It should be remembered that all measures not passed by Congress did not die on adjournment, but will retain their positions in committees or on Senate or House Calendars pending start of the second session in January.

The next session of Congress certainly will not be devoid of medical legislation. Commitments already made by the administration mean that amendments to the social security law, extending coverage to the self-employed (including physicians) will come up for decision. In the same connection, there may be action on bills (Jenkins-Keogh type) to permit the self-employed to defer income tax payments on funds paid into annuities as well as action on proposals to allow deduction for post-graduate education costs. These three matters now are under study by the House Ways and Means Committee. The House Veterans' Affairs Committee may have some legislation to propose on care of non-service-connected cases by Veterans Administration, a center of controversy in the last session. The two newly formed commissions on Organization of the Executive Branch and on Intergovernmental Relations, may be expected to offer bills with medical implications before the next session closes. It will be surprising if Congress does not take some definitive action on the long-delayed Bricker resolution concerning the making of international treaties and executive agreements.

Federal Aid to Medical Education

S. 461	Humphrey	Federal aid to schools of public health.	No action.
S. 1515	Hunt	Western Interstate Commission for higher education.	Became Public Law 226.
S. 1748	Taft	Federal charter for the National Fund for Medical Education.	Passed Senate July 6 and sent to House.
S. 2168	Langer	College scholarship loans.	No action.
H.R. 2838	Elliott	Federal aid to education.	No action.
H.R. 3850	Bolton (Mrs.)	Federal aid to nursing education.	No action.
H.R. 6079	Boland	College scholarship loans.	No action.
H.R. 6124	Lane	College scholarship loans.	No action.

National Health Programs

S. 93	Hill-Aiken	Federal aid to states for voluntary health insurance.	No action.
S. 1052	Humphrey	Loans to co-op and nonprofit health insurance associations.	No action.
S. 1153	Ives-Flanders	Federal aid to voluntary health plans, medical education, and health facilities.	No action.

H.R. 1817 Dingell	National compulsory health insurance.	No action.
H.R. 3582 Hale	Federal aid to voluntary health plans, medical education, and health facilities.	No action.
H.R. 3586 Javits	Federal aid to voluntary health plans, medical education, and health facilities.	No action.
H.R. 4128 Scott	Federal aid to voluntary health plans, medical education, and health facilities.	No action.
H.R. 4593 Hagen	Loans to co-op and nonprofit health insurance associations.	No action.
H.R. 57 Multer	Study of accident and health insurance.	No action.
H.R. 58 Multer	To finance H. Res. 57 above.	No action.

Social Security and Public Assistance

S. 1470 Kefauver	To extend social security coverage to physicians, lawyers, dentists, etc.	No action.
S. 1933 Humphrey	Two year extension of present rate of federal aid to public assistance programs.	No action.
S. 1966 Murray-Lehman	Hospitalization for the aged.	No action.
S. 2260 Lehman et al.	Revision of Social Security Act.	No action.
S. 2351 Sparkman-Hill	Two year extension of present rate of federal aid to public assistance programs.	No action.
H.R. 8 Dingell	Hospitalization for the aged.	No action.
H.R. 9 Dingell	To make waiver of premium provision operative.	No action.
H.R. 383 Byrd	Social security insurance for disabled persons.	No action.
H.R. 390 Celler	Hospitalization for the aged.	No action.
H.R. 431 Eberharter	To make waiver of premium provision operative.	No action.
H.R. 1376 Bryson	Social security insurance for disabled persons.	No action.
H.R. 2000 Rhodes	Social security insurance for disabled persons.	No action.
H.R. 2070 Bailey	Social security insurance for disabled persons.	No action.
H.R. 2087 Elliott	To make waiver of premium provision operative.	No action.
H.R. 2150 Van Zandt	Social security insurance for disabled persons.	No action.
H.R. 2446 Angell	Universal social security coverage with disability benefits.	No action.
H.R. 2447 Secrest	Universal social security coverage with disability benefits.	No action.
H.R. 3105 Van Zandt	Universal social security coverage with disability benefits.	No action.
H.R. 3487 Lane	Extension of social security coverage to physicians and other self-employed.	No action.
H.R. 3554 Zablocki	Social security insurance for disabled persons.	No action.
H.R. 3608 Kean	Extension of social security coverage to physicians and other self-employed and disability insurance.	No action.
H.R. 3777 Perkins	Social security insurance for disabled persons.	No action.
H.R. 4160 Kean	Waiver of social security premiums for disability.	No action.
H.R. 4676 Ford	Social security public assistance grants for recipients in private institutions.	No action.
H.R. 5533 Kean	To change method of computing monthly retirement payments.	No action.
H.R. 5917 Radwan	Social security insurance for disabled persons.	No action.
H.R. 6034 Dingell	Revision of Social Security Act.	No action.
H.R. 6035 Bolling	Revision of Social Security Act.	No action.
H.R. 6036 Roosevelt	Revision of Social Security Act.	No action.
H.R. 6041 Celler	Revision of Social Security Act.	No action.
H.R. 6042 Dodd	Revision of Social Security Act.	No action.
H.R. 6043 Eberharter	Revision of Social Security Act.	No action.
H.R. 6044 Elliott	Revision of Social Security Act.	No action.
H.R. 6045 Howell	Revision of Social Security Act.	No action.
H.R. 6046 Rhodes	Revision of Social Security Act.	No action.
H.R. 6056 Shelley	Revision of Social Security Act.	No action.
H.R. 6072 Holifield	Revision of Social Security Act.	No action.
H.R. 6115 Fino	Social security insurance for disabled persons.	No action.
H.R. 6128 Perkins	Revision of Social Security Act.	No action.

H.R. 6162	Dollinger	Revision of Social Security Act.	No action.
H.R. 6163	Fine	Revision of Social Security Act.	No action.
H.R. 6164	Klein	Revision of Social Security Act.	No action.
H.R. 6175	Buckley	Revision of Social Security Act.	No action.
H.R. 6180	Rodino	Revision of Social Security Act.	No action.
H.R. 6215	Addonizio	Revision of Social Security Act.	No action.
H.R. 6229	Metcalf	Revision of Social Security Act.	No action.
H.R. 6320	O'Brien (Mich.)	Revision of Social Security Act.	No action.
H.R. 6505	Bennett (Fla.)	To change method of computing federal share of public assistance programs.	No action.
H.R. 6663	Friedel	Amending social security work clause.	No action.
H.R. 6664	Heller	Revision of Social Security Act.	No action.
H.R. 6666	King	Amending social security work clause.	No action.
H.R. 6723	Price	Revision of Social Security Act.	No action.
H.R. 6796	Mack	Universal social security coverage.	No action.
H.R. 6812	Reed (N.Y.)	Revision of Social Security Act (Administration bill).	No action.
H.R. 6846	Kean	Revision of Social Security Act.	No action.
H.R. 243	Reed (N.Y.)	To authorize funds for social security study.	Passed House May 27.

Veterans

S.	370	Murray	Construction of 16,000 additional VA beds.	No action.
S.	609	Sparkman	Lengthening presumption of service connection for chronic and tropical diseases.	No action.
S.	762	Martin	Lengthening presumption of service connection for active tuberculosis, psychoses and multiple sclerosis.	No action.
S.	1068	Griswold-Ives	Hospital care and medical treatment for veterans residing abroad.	No action.
S.	2576	Dirksen	To provide additional compensation for service-incurred disability to lungs.	No action.
S.R.	24	Ferguson	To establish a permanent separate Senate Committee on Veterans' Affairs.	No action.
S.R.	66	Ferguson	Replaces S. Res. 24.	No action.
H.R.	25	Rogers (Mrs.)	Lengthening presumption of service connection for chronic and tropical diseases.	No action.
H.R.	28	Rogers (Mrs.)	Construction of 16,000 additional VA beds.	No action.
H.R.	33	Rogers (Mrs.)	Lengthening presumption of service connection for active tuberculosis, psychoses and multiple sclerosis.	No action.
H.R.	35	Rogers (Mrs.)	Hospital care and medical treatment for veterans residing abroad.	No action.
H.R.	45	Rogers (Mrs.)	Lengthening presumption of service connection for malignant tumors.	No action.
H.R.	46	Rogers (Mrs.)	Lengthening presumption of service connection for tuberculosis.	No action.
H.R.	54	Rogers (Mrs.)	To authorize appointment of chiropractors in VA.	No action.
H.R.	261	Elliot	Construction of 16,000 additional beds in VA.	No action.
H.R.	310	McDonough	Lengthening presumption of service connection for active tuberculosis.	No action.
H.R.	338	Rogers (Mrs.)	Outpatient treatment for nonservice connected total disabilities.	No action.
H.R.	1543	Doyle	Hospital care and medical treatment for veterans residing abroad.	No action.
H.R.	1573	Battle	Lengthening presumption of service connection for chronic and tropical diseases.	No action.
H.R.	2001	Rhodes	Construction of 25,000 additional VA beds.	No action.
H.R.	2097	Hagen	Lengthening presumption of service connection for pulmonary tuberculosis.	No action.
H.R.	2573	Rogers (Mrs.)	Emergency hospital care for veterans of Spanish-American War.	No action.
H.R.	2980	Rogers (Mrs.)	Optometrists in VA.	No action.

H.R. 3070	Frelinghuysen	Lengthening presumption of service connection for amyotrophic lateral sclerosis.	No action.
H.R. 4155	Elliott	Lengthening presumption of service connection for chronic and tropical diseases.	No action.
H.R. 4601	Teague	To clarify law on hospitalization of nonservice connected cases.	No action.
H.R. 5012	McCarthy	To establish conclusive presumption of service connection for active pulmonary tuberculosis and multiple sclerosis.	No action.
H.R. 5636	Radwan	Lengthening presumption of service connection for tuberculosis.	Became Public Law 241.
H.R. 5892	Rogers (Mrs.)	To increase Federal aid to State and Territorial homes for disabled military personnel.	No action.
H.R. 5893	Rogers (Mrs.)	Disability pensions for retired military personnel being treated in VA facilities.	No action.
H.R. 6015	Teague	To clarify law on hospitalization for veterans.	No action.
H.R. 6659	Curtis (Mass.)	To increase federal aid to State and Territorial homes for disabled military personnel.	No action.
H.R. 34	Rogers (Mrs.)	Investigation of VA by House Veterans' Affairs Committee.	Passed House March 5. Appropriation of \$50,000 voted March 16.
H.R. 140	Kelly	Investigation of medical and hospital facilities of VA.	No action.

Pension Plans

H.R. 10	Jenkins	Tax postponement for self-employed to create annuities.	Public hearings held by House Ways and Means Committee.
H.R. 11	Keogh	Tax postponement for self-employed to create annuities.	Public hearings held by House Ways and Means Committee.
H.R. 2533	Elliott	Tax postponement for self-employed to create annuities.	Public hearings held by House Ways and Means Committee.
H.R. 2692	Camp	Tax postponement for self-employed to create annuities.	Public hearings held by House Ways and Means Committee.
H.R. 5452	McDonough	Tax deductions for annuities.	No action.
H.R. 6114	Elliott	Tax postponement for self-employed to create annuities.	Public hearings held by House Ways and Means Committee.
H.R. 6509	Holtzman	Tax deductions for annuities.	No action.

Treaties

S.J.R. 1	Bricker, et al.	Relating to legal effect of certain treaties.	Public hearings were extended over several weeks. Senate Judiciary Committee favorably reported resolution June 15.
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THE JOURNAL

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HEMORRHAGIC CONDITIONS IN THE FIRST TRIMESTER OF PREGNANCY*

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THESE REMARKS deal with the common obstetrical complications which cause hemorrhage in the first trimester of pregnancy, i.e., abortion, hydatid mole, extra-uterine pregnancy, and certain pathological lesions of the cervix.

Abortion is that process which results in the delivery of a fetus weighing less than 500 grams.

Approximately 10 per cent of all pregnancies end in abortion.

The principal causes of spontaneous abortion are defective germ plasm, and abnormal uterine environment. A blighted ovum or a defective fetus are the most frequent causes of spontaneous abortion. Both of these abnormalities are believed to be due to defective germ plasm, either male or female.

Abnormal uterine environment may be:

- (a) Decidual abnormalities due to insufficient production of estrogen, progesterone, or thyroid hormone.
- (b) Structural defects of the uterus such as, double uterus or uterine fibromyoma.

Other causes of spontaneous abortion are acute febrile diseases and trauma.

*First of four papers given on panel discussion on "Obstetric Hemorrhage" at the 1952 annual convention of the Indiana State Medical Association.



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Clinically abortion may be classified as:

- Threatened or inevitable.
- Complete or incomplete.
- Induced or spontaneous.
- Clean or septic.

The symptoms and physical findings of abortion, i.e., cramping pain, vaginal bleeding and the expulsion of all or parts of the fetus, and placenta need only be named.

Differential diagnosis must be made from ectopic pregnancy, hydatid mole, cervical carcinoma, benign cervical lesions, and hemorrhage due to various types of pathological lesions from a non-pregnant uterus.

Diagnosis of abortion of an intra-uterine

pregnancy can only be made with certainty by seeing the aborted fetus or by histological examination of tissue passed showing presence of chorionic villi.

Treatment:

Threatened abortion is best treated by bed rest.

The use of diethylstilbesterol and progesterone is questioned by some, but the essayist uses both of these.

Diethylstilbesterol is given in 20 milligram daily doses, increasing to 40 milligrams daily, and then to 100 milligrams per day. Progesterone is given intramuscularly in 100 milligram doses daily.

If vaginal bleeding continues, the cervix should be inspected to determine whether the ovum or fetus is presenting in a partially dilated cervix, or whether the bleeding is coming from a pathological cervix. In this instance a cervical biopsy should be done.

If the cervix is found to be dilated with the ovum presenting, then the abortion is inevitable, and a decision should be made as to how soon active intervention should be undertaken. Profuse hemorrhage is a definite indication for active intervention in the form of a cervical dilatation and curettage with blood replacement.

If the hemorrhage is not profuse, the decision as to active intervention in inevitable abortion is not so urgent. Some patients may abort spontaneously and completely, but in most cases blood can be saved, and convalescence shortened by emptying the uterus certainly and completely by a sharp curettage. The chief hazard of curettage in incomplete or inevitable abortion is that of perforation of the soft friable uterine wall with a dilator or curette. This danger can be avoided by gentle, careful instrumentation.

The two principal causes of death in abortion are hemorrhage and infection. Active intervention combined with multiple transfusion is life saving. Infection should be prevented by proper aseptic technique or corrected by antibiotic therapy. Women should not die from abortion today.

Hydatid mole is due to the proliferation and degeneration of the chorionic villi. It occurs in about 40 per cent of all abortions, and in about 4 per cent of all pregnancies.

The clinical course is as follows: Vaginal bleeding is repeated and progressive in amount. The uterus may enlarge more rapidly than in normal pregnancy, but absence of this finding does not rule out hydatid mole. Hyperemesis occurs early and is severe. Idiopathic toxemia of pregnancy may develop. The quantitative Friedman test is strongly positive in most cases, but a negative Friedman does not rule out the possibility of an hydatid mole. Both ovaries are enlarged to several times normal size due to the production of multiple lutein cysts as a result of the production of excessive trophoblastic hormone. These ovarian cysts are not the cause of hydatid mole, but the result of it. They need no treatment and will regress to normal status after the removal of the hydatid mole.

Expulsion of the characteristic grapelike cysts makes the diagnosis easy. However, the condition may not be diagnosed until abortion occurs and microscopic tissue examination reveals the characteristic changes in the chorionic villi.

Abortion of an hydatid mole is usually slow, sluggish and accompanied by hemorrhage which may be profuse.

Hydatid mole is a benign lesion, but nevertheless the uterine wall may be invaded. This invasion of the uterine musculature probably is the reason why it is so easy to perforate the uterine wall when curetting a uterus to evacuate an hydatid mole.

A sharp curettage should be done as soon as the diagnosis is made, or when blood loss is continued and progressive. Even if the mole is aborted spontaneously, a sharp curettage should be done to reduce the possibility of the development of chorio-epithelioma.

Patients with hydatid moles should be followed for two years. Persistent uterine bleeding and a persistently positive Friedman or Ascheim-Zondek test for more than 12 weeks is indicative of a chorio-epithelioma. Chorio-epithelioma is more frequent after an hydatid mole in women of 40 years of age or more. Routine total hysterectomy and bilateral salpingo-oophorectomy are therefore indicated in such patients.

Extra Uterine Pregnancy

The incidence of extra-uterine pregnancy is about 1 in 165 live births. Of all extra-uterine pregnancies about 94 per cent are tubal, 3.6 per

cent are interstitial, 1.4 per cent are abdominal, and .7 per cent are interligamentous.

The causes of extra-uterine pregnancy are:

- (1) Previous salpingitis.
- (2) Pelvic adhesions.
- (3) Infantile tubes with imperfect development of cilia.
- (4) Tubal diverticulae.
- (5) Spasm of the tube.
- (6) Endometriosis.

Tubal pregnancy ends in spontaneous tubal abortion in over 50 per cent of the cases. Most patients with tubal abortion recover without surgery or often without a diagnosis having been made. The patient usually misses one period, or at least has had some abnormality of her last period, then develops pain in the region of the affected tube with some symptoms of moderate blood loss and peritoneal irritation. These patients are often operated for ruptured tubal pregnancy because the symptoms and physical findings are similar. This is not a serious error in that it is much better to operate the patient unnecessarily for tubal abortion than to delay operation in a ruptured tubal pregnancy.

Patients whose tubal pregnancy does not end by tubal abortion will have missed one to two periods, or at least have had some abnormality in their menstrual cycles, and may have signs and symptoms of early pregnancy such as malaise, nausea and a positive Friedman. Abdominal pain which is cramping in nature and is on the side of the affected tube is characteristic of tubal pregnancy. There may or may not be uterine bleeding. The patients may or may not pass particles of uterine decidua. Vaginal examination may reveal a mass in the affected tube which is painful and tender to manipulation, or there may be no demonstrable tubal mass. The uterus is usually somewhat enlarged and somewhat soft as in an intra-uterine pregnancy. The tube may rupture as a slow leak, in which case there is continued abdominal pain on the affected side, increasing tenderness on vaginal examination, continuation of the vaginal bleeding, and the formation of a mass in the cul-de-sac, which is crepitant to touch and which may be demonstrated by cul-de-sac aspiration to be composed of clotted blood.

The rupture of the tube may be explosive in character in contrast to the slow leak. In this case

there will be a sharp stabbing or tearing pain over the affected tube with symptoms of massive intra-abdominal hemorrhage with low blood pressure, thready pulse, fainting and the usual picture of shock. From the standpoint of differential diagnosis ruptured tubal pregnancy is sometimes diagnosed as salpingitis, acute appendicitis, abortion of an intra-uterine pregnancy, or an ovarian cyst on a twisted pedicle. These are the common diagnostic errors. Salpingitis is usually bilateral, is accompanied by fever and presents no shock symptoms. In abortion of an intra-uterine pregnancy, the symptoms of blood loss are in proportion to the visible blood loss, and histological examination of curettings will show chorionic villi; while in tubal pregnancy such curettings will show a decidual reaction, but no chorionic villi. In acute appendicitis there are no signs of pregnancy. There is usually more muscle spasm, the white count and differential counts are more indicative of infection, the patient is flushed and excited rather than in a state of shock, and pelvic findings are those of a non-pregnant uterus. In a patient who has an ovarian cyst on a twisted pedicle, there are no signs or symptoms of pregnancy. The ovarian cyst is easily demonstrable and tender.

The treatment of tubal pregnancy is immediate surgical removal of the affected tube accompanied by prompt, adequate blood replacement. We should remember while considering the patient with a possible ruptured tubal pregnancy that we can be too scientific in working out an accurate diagnosis, and thereby lose the patient because of the delay. We can not always be sure of our diagnosis before laparotomy, but we can say to ourselves: "Here is a woman who is seriously ill from blood loss. The amount of vaginal bleeding which I have seen is not enough to account for her symptoms of blood loss. She has missed a menstrual period, she has a somewhat enlarged soft uterus and has some tenderness in the region of one tube. She therefore probably has a ruptured ectopic pregnancy, and is probably still bleeding." This kind of approach will be correct in most instances and will save lives.

One brief case history illustrates the problem of tubal pregnancy. A 37 year old woman was seen for the first time on September 5, 1952, with a history of infertility, and having had her last menstrual period July 26, 1952, with a little

spotting on August 31, 1952. Pelvic examination showed a uterus which was possibly a little enlarged and which was definitely soft. There was slight tenderness to palpation in the region of the right tube but no mass was felt. A diagnosis was made of a probable intra-uterine pregnancy. Five days later the patient developed a sudden sharp stabbing pain in her lower right abdomen; was seen within two hours of the onset of her pain at which time she had an imperceptible radial pulse, a systolic blood pressure of 90 mm, and a diastolic of 40 mm, and presented a typical picture of surgical shock. She was given 100 milligrams of demerol by hypodermic injection; was sent to the hospital by ambulance. On admission a typing and compatibility were done for a 1000 cc of whole blood; she was given 500 cc of O Rh-negative blood containing 10 cc of Witebskey's substance; and was prepared surgically. Including her trip to the hospital by ambulance she was in the surgery within 45 minutes of the time she was first seen. At the time the anesthetic was started her blood pressure was 60 mm systolic, and 40 mm diastolic, she had air hunger, and her fingernails were cyanotic. No time was taken for a pelvic examination. An immediate laparotomy was done. A ruptured right tubal pregnancy was present. There was at least 1500 cc of blood in the peritoneal cavity. A left salpingectomy was done, the free blood in the peritoneal cavity was aspirated, and the abdomen closed quickly. All this time the patient had been receiving blood under pressure, and her blood pressure had risen to 110 mm systolic and 70 mm diastolic. In all 3000 cc of blood were given. The patient's recovery was uneventful.

The question has been raised as to what to do

with the blood in the peritoneal cavity. It is my opinion that rapid removal of free blood and blood clots from the peritoneal cavity smooths out the convalescence of the patient. She needs blood in her circulatory system and not in her peritoneal cavity if she is to live. The question also arises as to the advisability of doing any additional surgery. It is generally believed that additional surgery is contraindicated in the presence of free blood in the peritoneal cavity.

A few remarks are in order regarding interstitial pregnancy. The interstitial portion of the tube is that portion which goes through the cornu of the uterus. If a fertilized ovum implants itself in this interstitial portion of the tube, we are facing one of the most dangerous situations in obstetrics, in that the rupture is explosive in character, and the blood loss is so rapid and extensive that death occurs rapidly unless an immediate laparotomy is done. These interstitial pregnancies rupture any time or may go four to six months before rupture. About the only symptoms and physical findings of interstitial pregnancy which are helpful are that the patient has pain in the region of the affected cornu, and has a uterus of irregular shape, the uterus being enlarged more in the affected cornu than it is generally. An exploratory laparotomy is justified if this condition is suspected.

Cervical Carcinoma in Pregnancy

Carcinoma of the cervix in pregnancy is not too common an occurrence fortunately, but is certainly a fatal disease if not diagnosed early. The only way an early diagnosis of cervical carcinoma can be made is by inspection of the cervix in every patient, and by biopsy of pathological or suspicious cervical lesions.

PLACENTA PRAEVIA*

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IN CONSIDERATION of the obstetrical problem of placenta praevia one must give thought to the possible occurrence of perhaps the widest variations of symptoms plus the ever present threat of severe hemorrhage which may result in the death of the patient and her baby.

The most common cause of antepartum bleeding is the partial separation of a placenta in which at least a portion is implanted in the region of the internal os of the cervix. Painless, causeless, continuous or reoccurring hemorrhage in the third trimester of pregnancy is the characteristic and almost certain symptom of placenta praevia. Earlier indication of this condition is associated with a small portion of spontaneous miscarriages.

Numerous theories have been advanced as to the cause of placenta praevia but the true cause remains unknown. Careful observation has found the condition more often associated with multiparity and endometritis may be a predisposing factor to low or faulty implantation of a placenta.

The incidence of the condition varies statistically but it probably occurs about once in every 250 deliveries. The mortality also varies somewhat depending upon the severity of the problem presented and the availability of facilities to combat the complications. In general, maternal mortality from placenta praevia may range from two to ten percent and fetal mortality from 25 to 50 percent. In the main, prognosis for the mother depends upon the control of antepartum and postpartum hemorrhage and the prevention of sepsis plus the avoidance of complications resulting from a traumatic delivery. The loss of babies is largely due to prematurity, asphyxia due to hemorrhage and injury due to hasty and difficult delivery.

In this short presentation, I shall not attempt to discuss the somewhat academic question as to

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the varieties of placenta praevia. In most cases the decision as to the handling of the problem rests on the severity of the symptoms present. In general, the most severe type, namely, central placenta praevia, announces itself by the hemorrhage encountered.

A diagnosis of placenta praevia must be considered in any maternity patient near term who demonstrates external bleeding in any quantity in excess of the usually recognized 'show'. This is more especially true when the condition arises at or about the seventh or eighth month without accompanying signs of labor and in the absence of tonic rigidity of the uterus. In most instances the active bleeding occurs without any forewarning and may occur while the patient is soundly asleep. The amount of bleeding may be of hemorrhage proportions at the very onset. With a warning signal of bleeding as noted above, the diagnosis of placenta praevia must be given the number one spot for consideration. The need for hospitalization is imperative and should be insisted on if at all possible. The patient should preferably be sent to the hospital by ambulance for observation, decision and treatment. Since hemorrhage plays such an important role in this scene, immediate plans must be made to combat blood loss both present and future. No examination or treatment is worthwhile until blood is available and is being replaced at a rate approaching the rate of bleeding. Temporary intravenous

* Second of a series of papers on "Obstetric Hemorrhage" given at the annual convention of I.S.M.A. in 1952.

solutions are very helpful while blood is being prepared and there is certainly great satisfaction in having an adequate size needle carefully anchored in a vein. However, even though the vaginal bleeding stops, continue to get blood available for there is no substitute for whole blood in such or any case of hemorrhage.

It would be tedious to review all of the various possible degrees of severity of placenta praevia but it is sufficient to say that after the above item of blood is arranged for, then and only then is the review of the problem, the examination of the patient and choice and course of treatment in order. Abdominal examination is often very helpful; size of the baby may be estimated and viability determined. Finding the presenting part high and unable to enter the pelvis or in an unusual position arouses suspicion that the placenta is low in the pelvis and obstructing the birth canal.

The decision to procrastinate is often appealing especially when the blood loss has not been extreme and the baby is small and more especially when the bleeding subsides. Such consideration has some merit, as rarely is the first or early bleeding of placenta praevia fatal. When such a decision is made adequate blood should be on hand and the accoucheur must be readily available at all times to carry out adequate emergency care for a very severe hemorrhage may occur at any time following an early episode of innocuous bleeding.

Again if the patient is near term and no unusual presentation of the baby is noted abdominally, I feel a very careful rectal examination may reveal the presenting part well in the pelvis, the cervix soft and partially dilated, and then simple rupture of the membranes will usually initiate labor, help control bleeding and further a successful outcome of the problem.

Undoubtedly the most successful way to determine the patient's status is to have all equipment ready so that vaginal manipulation or delivery by Caesarean section may be done at once and then do a sterile vaginal examination in the operating room. Care and caution must be exercised and this can't be emphasized too much, for one certainly has little desire to witness the severe bleeding following the separation of a central placenta praevia after a rough pelvic examination. On such occasions one is indeed glad that blood is ready and that preparations are at

hand in the operating room for an immediate Caesarean.

Other procedures are available that may be carried out by vaginal route. These include as mentioned: artificial rupture of the membranes, introduction of a Voorhees' bag, bipolar version and traction on the baby's scalp by use of the Willett's forceps. All such procedures are, of course, for the purpose of attempting to control bleeding by pressure or traction and to stimulate and further labor so that delivery will be accomplished. Such procedures are usable in select circumstances and all have strong advocates who have had considerable success in their usage. All of these procedures depend upon the status of the cervix and often on the parity of the patient. In some cases it may be possible to carry out one of the above and accomplish delivery before a surgical procedure can be carried out. Again prolongation of the labor process may mean added bleeding, increase chance of sepsis and possibly a traumatic delivery or a delayed surgical procedure to finish the delivery.

Whether one makes the choice of delivery from below or Caesarean section must depend on the findings as related to the individual patient. Due respect must be given to the status of the cervix and its potential ease and speed of dilatibility. Too much bleeding associated with a long labor or trauma from a difficult delivery to hasten the process by the vaginal route may make such a choice extremely hazardous for the patient.

Caesarean section has increased in incidence for the treatment of at least the more severe cases of placenta praevia. It offers a quick way out when hemorrhage is acute, however, it offers no better avoidance of postpartum hemorrhage than delivery by the vaginal route as retroplacental sites in the non-contractile portion of the uterus may bleed following delivery by either choice.

Selection of the mode of delivery and handling of the case of the placenta praevia may tax the ingenuity of the most astute accoucheur and a disastrous result may occur in the most capable hands. No hard and fast rules can be made except to always be sure to have adequate blood available. Each problem must be individualized and a decision made for the best and most likely choice for salvage of both mother and baby. Emphasis must again be placed on the need for caring for the patient in the hospital, the need

for adequate blood to replace the loss at bleeding and the need for an adequate and readily available team of doctors and nurses ever alert to the symptoms and potential dangers of this complication plus the facilities and equipment to carry out whatever procedure may be necessary.

Early recognition, adequate care and treatment offer a good chance of reducing the maternal and fetal mortality associated with placenta praevia with its associated bleeding which is still one of the leading causes of maternal and fetal deaths.

ABRUPTIO PLACENTAE*

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ABRUPTIO PLACENTAE is a grave obstetric emergency in which the patient's life and that of her baby may depend on speed and adequacy in treatment. It is so varied in degree that it may range from the presence of a small clot on the maternal surface to that of complete separation with immediate death of the baby. It must be remembered that unlike placenta previa the condition is often progressive, a small separation changing to complete separation in a short period of time.

Above all things, the patient must be cared for in a hospital with a blood bank as hemorrhage is the greatest cause of death in these cases. Whether treatment is radical or conservative, blood and more blood is the backbone of therapy.

Incidence. Decided differences in incidence have been reported by many authors. In 1944, I made a study of those abruptios occurring at the Coleman Hospital and the Indianapolis General Hospital in the ten years preceding. There were 54 cases of abruptio in 18,202 deliveries, an incidence of 1-337. In the severe cases, the incidence was 1-2,250.

Etiology. The etiology is still obscure. About 65% are associated with toxemia especially of the hypertensive type. Traction on a short cord may occasionally be causative while attempts at



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external version and multiparity are also pro-
vocative. Trauma may be the etiology in a small
percentage of cases.

There is little that prenatal care can do in the
prevention of the condition except possibly in-
duction of labor in the hypertensive cases, limita-
tion of travel in pregnancy and great care when
external version is attempted.

Diagnosis. The condition is most often con-
fused with placenta previa. The latter will show
no difference in abdominal palpation than will
the normal case at term. In the severe case of
abruptio, it will be difficult to outline the baby,
there will be no fetal heart tones, the abdomen
boardlike and the degree of anemia may be all

* Third paper in panel on "Obstetric Hemorrhage"
given at 1952 annual convention of Indiana State
Medical Association, Indianapolis.

out of proportion to the visible blood loss, especially in those cases of so-called concealed hemorrhage. A sterile vaginal examination will show placental tissue over the internal os in the case of placenta previa.

In the case of severe traumatic abruptio, it may be impossible to distinguish the condition from that of ruptured uterus. Abruptio may also be confused with rupture of the lateral sinus and with vasa previa.

Management. In considering the treatment of abruptio, it is apparent that individualization is necessary. Much depends upon the severity of the symptoms, parity of the patient, condition of the cervix, whether or not the baby is alive or jeopardized by asphyxia and whether or not the patient is in labor. It seems better to classify patients according to the severity of maternal symptoms rather than to attempt a pathological classification, which is impossible to demonstrate at the time treatment must be inaugurated. In the study previously mentioned, I divided the cases into mild, moderate and severe as had been suggested by McCord and others.

The Mild Cases

Here we may have just a small clot on the maternal surface of the placenta with no maternal symptoms and no change in the fetal heart. In a few instances, there may be marked infarction and separation of the placenta without signs or symptoms except loss of fetal heart. Also in this group are included those cases of slightly increased bleeding during labor with little or no change in fetal heart. Often labor is so augmented that it is terminated in a short time. Diagnosis is usually obscure until actual delivery has been completed. In the group in the previous study, there were 15 cases. Trauma was responsible for one, syphilis was present in another, toxemia in three, while in the remainder there was no demonstrable cause except that one placenta separated during a breech extraction. Only one patient required transfusion. In one case, the membranes were ruptured artificially. There were two breech extractions, four low forceps and the remainder delivered spontaneously. Prematurity was present in one-third of the cases evidently caused by the abruptio. There were two stillborn babies and one neonatal death in the series of 15 cases. In this group interference is almost always unnecessary, and the

chief importance is the fetal loss due to prematurity and asphyxia and the danger of a more severe type of abruptio developing.

The Moderate Cases

Here a definite diagnosis can be made and it is usually during labor. There is external bleeding but shock is not present. Fetal salvage is often still possible. In many the labor has started and is completed in a short time. Some will be in the second stage of labor and, if the fetal heart is failing, can be terminated by low forceps. In the primipara just starting labor, cesarean section has its greatest use as the patient is in good condition and the baby can usually be saved. Administration of oxygen to the mother is very beneficial to a failing fetal heart while preparing for operation.

In our previous study, there were 31 cases of moderate severity. Toxemia was associated with one-third. Twenty of the 31 were premature labors.

The Severe Cases

In this group are those patients entering the hospital in shock, with boardlike abdomen and no fetal heart tones. These are the patients where the greatest difference of opinion exists as to proper treatment. Our viewpoint is as follows: Instead of procrastination while preparations are being made for transfusion, inauguration of conservative treatment should be attempted in those patients not in labor. A sterile vaginal examination is made and if the cervix is ripe, the bag of waters may be ruptured in the patient's bed. We have used Spanish windlass in the past and some have employed Beck's abdominal binder. Recently Gordon warned against the possibility of these devices injuring the already damaged uterus. Pitocin drip should be started, using 5 m. in 500 cc. 5% glucose in D/W. We formerly used 1 m. doses of pituitrin for about three doses.

The question now is (1) whether the uterus can be stimulated to rhythmic contractions so that the baby may be expelled, and if so, (2) whether the activity of the uterus will be sufficient to control hemorrhage in the early postpartum phase. The patient must be constantly watched.

Watch for Acute Renal Failure. In 6 to 10% of the more serious cases, lower nephron nephro-

sis and/or cortical necrosis may occur. The urine output must be carefully watched. Continued low blood pressure means increasing tissue anoxia with the ever present possibility of irreversible changes in the kidney. Prolonged or extensive renal spasm will result in cortical necrosis. Less extensive spasm causes lower nephron nephrosis and these conditions may follow incompatible transfusion. If oliguria persists, Gordon suggests low spinal anesthesia in an attempt to relieve arterial spasm.

Fluid balance must be obtained. Intake of fluids should never exceed the insensible loss (about 1 liter) plus the equivalent of the previous day's urinary output. If there is oliguria, the anemia should be treated with packed red cells rather than whole blood.

Watch for Disturbances in Blood Clotting Mechanism. In 1901, DeLee called attention to the fact that some of the severe cases would experience a change in clotting time and termed the condition "temporary hemophilia." Recently considerable work has been done by Reed, Page, Schneider and others on this mechanism. As the result of the absorption of a placental or decidual substance, probably thromboplastin, a rapid and diminished intravascular coagulation occurs involving chiefly the arterioles and capillaries. The thromboplastin reacts with prothrombin to form thrombin which, in turn, acts on fibrinogen causing its depletion with the formation of fibrin. When this occurs, bleeding becomes uncontrollable and may be from the uterus, cervical stump, vaginal wall or episiotomy. To guard against this complication, a 5 cc. sample of patient's blood should be taken at hourly intervals, labeled and allowed to stand at room temperature. If there is still a clot at the end of an

hour, serum fibrinogen is adequate. If the clot disintegrates in a few minutes, termination of the pregnancy is indicated. In the presence of this abnormal clotting mechanism only fresh bank blood should be given or fibrinogen if it is available.

In many cases after rupture of the membranes, labor will start and terminate satisfactorily. However, if the patient is losing ground in spite of transfusion, as evidenced by frequent blood pressure readings and the character of the pulse, or if she shows abnormal clotting time, more blood should be given and cesarean section done. Polak recognized this possibility and one of his 16 patients was so treated. In 34 patients treated conservatively, Irving had only one case where the uterus would not expel its contents. If the uterus is not able to do its work properly after the third stage, uncontrollable postpartum hemorrhage may occur and hysterectomy may be necessary. O'Regan reported two deaths from this. One patient at Coleman was saved by blood and hysterectomy.

The appearance of the uterus is not a good criterion as to its ability to contract. If one does a cesarean section and removes the uterus because it shows hemorrhage under the serosa and in the region of the great vessels, then many uteri will be needlessly sacrificed. It is the ability of the uterus to contract and not its appearance that is important. Occasionally, in a uterus left at cesarean section, another operation may be necessary for its removal because of persistent bleeding. In our previous study, I reported eight of the severe group, 3 treated by immediate cesarean section, 4 treated conservatively and 1 by the combined method, i.e., delivery from below followed by hysterectomy. All babies were dead and none of the mothers were lost.

POSTPARTUM HEMORRHAGE*

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THERE appears to be general agreement that blood loss is responsible, directly or indirectly, for the greatest part of morbidity and mortality associated with the pregnancy state. This is especially true of the postpartum period. Much of the morbidity and mortality attributed to infection is due to the lowered resistance caused by blood loss. The reason the results of blood loss are not worse is because of the availability in recent years of antibiotics and the ability to replace blood with saline-glucose, plasma, and whole blood. It is a sad accusation of the present state of obstetrical care, and yet it is a hopeful thing, that much of this morbidity and mortality can be considered preventable.

Prevention, not treatment, of postpartum hemorrhage should be the aim. Since we have good analgesic and anesthetic drugs available for the first and second stages of labor, there is little reason why the physician should be harassed by the patient or the relatives into a forceps operation or breech delivery before the cervix is completely dilated and the presenting part at least to the mid-station. The results of such premature attempts at delivery are severe cervical, ragged vaginal, and deep perineal tears. Such tears contribute to postpartum hemorrhage, uterine atony, and shock.

It is unwise to attempt a difficult forceps delivery or breech extraction without the proper conditions to repair deep tears and combat hemorrhage. Unless one is sure of completing a difficult forceps or breech delivery, it is unnecessary and unwise to make an episiotomy before the attempt at delivery. Women have gone into shock from bleeding from an episiotomy wound after a failed-forceps or failed-breech delivery before other assistance, or before delivery, has been obtained; or such bleeding may contribute



MacKenzie

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to shock in the early postpartum period. It is not imperative that a vaginal delivery be done. A cesarean section may be much safer for the mother and the child so far as life is concerned, and much less traumatic.

A patient should not be allowed to become exhausted in labor. The sun should not set twice on a woman in labor without serious concern on the part of her physician. Ether is perhaps the safest anesthetic for the second stage of labor when properly given. However, one should avoid the prolonged use of a general anesthetic—especially deep ether—since it predisposes to uterine atony postpartum.

One can expect trouble postpartum in caring for the woman who has had multiple full term pregnancies. One can look for a precipitate delivery, slow separation of the placenta, and atony of the uterus, all of these predisposing to hemorrhage. One must be on guard also for trouble after the birth of an over-size baby, after twins, and with polyhydramnios.

To prevent postpartum hemorrhage one should have immediately available the drugs and materials generally considered necessary to combat hemorrhage. They include sterile hypodermic

* Fourth and last of a series of papers on "Obstetric Hemorrhage" given at the 1952 annual convention of the Indiana State Medical Association.

syringes and the proper needles, pitocin or pituitrin, methergine or ergotrate, intravenous saline solution, saline-glucose solutions, and plasma. Where hospitals have blood banks, a pint of O type-Rh negative blood should be kept in the ice box on the obstetrical floor for emergency. (The half hour necessary to obtain typed and matched blood for transfusion is sometimes too long in acute, severe hemorrhage and shock.) Otherwise, plasma or saline-glucose will have to be the stop-gap. Oxygen should be available by mask for shock. A ten-yard gauze pack, either iodoform or to be used with such a solution as acriflavin 1-1000, should be ready in a sterile jar.

The conduct of labor has an important part in determining placental separation and blood loss. The following care of the ordinary case of labor has been used for the past eight years with satisfaction. The nurse has ready in one syringe, one unit of pitocin in one cc. of saline solution (1 cc. pitocin, or 10 units, diluted to 10 cc. with saline solution in a rubber stoppered bottle from which 1 cc. is drawn.) In a second syringe is one ampoule of methergine. (Methergine is preferred to ergotrate since it is felt that ergotrate is more likely to cause hypertension immediately postpartum.) As soon as the baby's chin is born, I ask the nurse to give the one unit of pitocin intravenously. This is usually accomplished by the time the first shoulder is delivered. If one is to expect the placenta to follow soon after the birth of the baby, the baby should be delivered slowly, say, patient delivery of the head, one minute for the shoulders, and one minute for the body. As soon as the head is born, blood and mucus are wiped from the face; when the shoulders are born the throat is sucked clear with a bulb syringe and it is then that the baby is likely to take its first breath. There is seldom need for hurry at this stage. I believe the slow delivery is responsible for allowing the uterus to contract and separate the placenta properly; the pitocin is there to help stimulate the uterus to contract and start the expulsion of the placenta as soon as it separates. In the event no one is available to give the pitocin intravenously, 1 cc. of pitocin (10 units) may be given intramuscularly as soon as the first shoulder is born. I believe a placenta is less likely to be retained following a breech extraction which is, by nature, slow. With a breech, I ask that the one unit of pitocin be given intravenously as soon as the

Piper forceps are properly applied for delivery of the head.

I believe that in 90 percent of the cases, the placenta presents in the cervix, even in the vagina, within two to four minutes after delivery of the baby. There is little or no difficulty in delivering a placenta, which has properly separated, by gentle traction on the cord with one hand and by elevating the uterus into the abdomen or by gentle fundal pressure with the other hand. Traction is never made on the cord unless the placenta can be felt presenting in the cervix, or can be seen in the vagina, and traction is only to guide the placenta out. As soon as the placenta is delivered, the one cc. of methergine is given intravenously. The placenta and membranes are carefully examined for evidence or retained portions. If there is any doubt about this, the inside of the uterus is explored without delay.

If the placenta is out completely and the uterus relaxes and bleeds easily after the methergine is given, a full cc. of pitocin (10 units) is usually given intramuscularly to hurry up the muscular contraction while waiting for the more slowly acting methergine. If there are some minutes delay before the placenta is ready for delivery, the baby is cared for, the cervix, vagina, and episiotomy are inspected to plan, or start, the necessary repairs. The fundus of the uterus is watched by palpation only. The Credé method of attempt at delivery of the placenta is not used. So long as the uterus does not bleed it is not bothered except to frequently feel to see that it does not relax and bleed, and to determine the earliest time the placenta is ready for delivery. When no repair is needed and if no blood is being lost, there need be no hurry to deliver the placenta. With this conduct of no massaging and watchful waiting it is felt that 98 percent of placentae will separate spontaneously and can be delivered within eight to ten minutes. When an ergot preparation has been given before the placenta is expelled from the uterus it may be necessary to wait a while for the uterus to relax.

It is a very small percentage of placentae that should give trouble. If there is a steady oozing of blood to indicate partial placental separation and 200 cc. to 300 cc. of blood loss, the placenta is delivered manually. I believe that manual delivery is much to be preferred to the traumatic Credé attempts at delivery. Where one has made

an episiotomy, and where there are cervical, vaginal, and perineal tears to repair, I see no reason to wait longer than 15 or 20 minutes to deliver the placenta manually if the cervix is relaxed enough to do it. Occasionally some general anesthesia is necessary to accomplish this for the comfort of the patient.

I do not believe the attending physician should get farther away than an arm's length from a patient who still has a placenta in her uterus. I believe she should never be put back to bed in the ward to wait until a placenta delivers spontaneously. Under the ordinary, careful, sterile delivery conditions, I believe there is very little danger in the manual delivery of the placenta. The placenta should be removed in one piece if possible and the uterus re-examined to be sure no fragments remain. It is extremely rare that one is confronted with a placenta accreta and one might as well find it out in 20 minutes as after several hours of uterine bleeding and impending shock.

It is felt that a uterine pack is rarely needed. An empty uterus seldom bleeds if oxytocics are properly used. A pack is not the proper way to control bleeding due to retained placental or membrane fragments. Many obstetricians believe a pack keeps the uterus from properly contracting and shutting off its blood vessels. A ten yard, three inch wide pack in a poorly-contracting, bleeding uterus may absorb 1000 cc. of blood and give a false sense of security. A second pack cannot be expected to be better than the first. A pack may help stop oozing from a low-lying placental site after delivery or from multiple tears of the cervix or vagina.

If a uterus is packed, it should be filled from the fundus and the vagina also packed so that the uterus may be compressed upon the pack through the abdominal wall if necessary. Apparently at times the pack will act like a foreign body and cause the uterus to cramp down upon it. If one uses a pack and the bleeding is controlled, it is not likely that harm is done but it is wise to use antibiotics prophylactically. However, I repeat, it is rarely necessary to pack a uterus that is free of placenta and membranes.

In the grand multipara with atony and hemorrhage, almost anything is justifiable to make the uterus contract; that is, one hand in the uterus itself or in the vagina and one compressing the uterus from the outside, one cc. of pitocin direct-

ly into the uterine muscle through the abdominal wall, or compressing the abdominal aorta through the abdominal wall. For a persistently bleeding uterus due to atony, a hysterectomy may be rarely necessary, or for uterine rupture, after an abruptio placenta, uterine fibromyoma, or placenta accreta.

The physician should become alert if 300 cc. of blood are lost and not waste time in stopping it. It is more blessed to save blood than to give. If 500 cc. have been lost, the woman is having a postpartum hemorrhage and at least by now, means should be started to replace it. The tendency is for the physician to underestimate blood-loss and be surprised when the patient begins showing signs of shock.

If a patient is markedly anemic before delivery, if she is a grand-multipara, if she has any bleeding of undetermined cause, if she is losing blood from a marginal placenta previa or abruptio placentae and the physician has decided to deliver her by the vaginal route, blood should be available before delivery is started. One thousand cc. of saline solution should be running into one arm at least, with not less than an 18 gauge needle, so that blood can be added without delay. In any case, whether blood is needed or not, the saline-solution with an added one cc. or 10 units, of pitocin can be continued in the patient's room to assure good contractions during the uncertain, immediate after-delivery period. However, one or both arms can be used for blood if this should be necessary.

If not actually present, the physician should be available for at least one hour after a newly delivered mother returns to her room. A nurse should carefully watch the pulse, the blood pressure, the fundus, the perineum for hematoma formation, and the amount and character of the visible bleeding. Bright red bleeding with a steadily firm uterus likely means bleeding from tears; dark bleeding with intermittent clots and softening fundus means uterine bleeding. Careful repair of cervical and vaginal tears is essential to prevent postpartum hematomas. Such a hematoma is often shock-causing out of proportion to the blood loss. The only treatment is to open the wound with an anesthetic and blood transfusion, and to make correct repair after finding the bleeding blood vessel or area.

On the premise that an empty uterus after delivery does not bleed, I instruct the nurse to

press on the fundus to expell clots if present but not to massage the uterus so long as the fundus is firm. There is a standing order to repeat pitocin or an ergot preparation as indicated. I feel it is as logical to actively massage a uterus post-delivery, that is not bleeding, as it is to ask a patient who is trying to control a nosebleed to keep blowing his nose. Massaging the uterus breaks up the blood clots in the uterine vessels which are a large factor in preventing bleeding.

It is wise to have one nurse rather than several responsible for the watching of a patient during

the immediate postpartum period. One nurse will be more impressed with changing six saturated peripads in rapid succession than six nurses changing one pad each. In hospitals where several mothers need postpartum watching at the same time, a recovery room is to be desired.

It is often the patient with a single large gush of blood, which is alarming but not necessarily dangerous, who gets careful attention, while the patient with the unalarming but continuously repeated, small blood losses is neglected and ends up with a dangerous shock.

SUDDEN DEATH IN INFANCY

Feeling that sudden death in infancy is too often ascribed to mechanical obstruction such as suffocation or enlarged thymus, this author reviews the literature on this subject, using both case studies and statistics. He feels that too often the true natural cause of death is missed because of gross rather than microscopic examination of body organs, because vomitus in the bronchial tree is assumed to be the actual cause of death, and because an underlying severe infection is missed. As far as the role of thymic enlargement in these deaths he refers to Farber's study of the thymus in 2,000 consecutive autopsies in which no pathologic gland was seen and where some other significant cause of death was found in all cases, and he concludes, "pathology of the thymus gland leading to sudden and unexpected death must be viewed as a most improbable and infrequent occurrence and one which most authorities in the field are unwilling to accept". In his summary he says, "a review of the literature shows that the consensus of opinion is that when an infant is found dead in bed it is very unlikely that accidental mechanical suffocation has occurred. It is more probable that some natural but unrecognized disease process has been operating, which in about 80% of cases is some form of acute respiratory infection".

Nevius, W. B.: Sudden Death in Infancy. J. Med. Soc. N. J. 50:242, June 1953.

ALLERGY OF THE SKIN AS SEEN IN OPHTHALMOLOGY AND OTOLARYNGOLOGY*

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ALTHOUGH the otolaryngologist and the ophthalmologist are not especially interested in general dermatology, each frequently encounters allergic skin lesions in the daily routine practice of his own particular specialty. The external ear, the eyelids, the lips and other parts of the face are frequent sites of allergic dermatitis which may spread rapidly to the skin surrounding the area first involved.

Allergic dermatitis may be classified according to the manner in which it is contracted, i.e., (1), the contact type, or dermatitis venenata, from direct external exposure to the offending substance, and (2), the internal or intrinsic type, by absorption of foods or drugs from the alimentary tract or from the parenteral use of drugs. The lesions of the two types vary somewhat. Contact dermatitis may show only a mild erythema or may produce a more severe vesicular form of rash, while intrinsic dermatitis may develop various types of eruption, such as erythema nodosum, hives, eczematous lesions of all degrees, and the diffuse, widely spread maculopapular eruption typical of dermatitis medicamentosa.

One writer (Andrews—quoted by Dr. D. J. Wilson—Nebraska Medical Journal—1947) states that over 200 drugs in common use are known to produce dermatologic reactions. Many of these drugs, such as penicillin, sulfonamides, barbiturates, aspirin, butyn, atropine, etc., are used freely in EENT practice and may cause allergic dermatitis either of the contact or internal type. Persons who react to internal medication, e.g., with sulfonamides, are very apt to develop the same symptoms from external contact with the drug. Also, the converse is true and after contact sensitization has been established the same reaction will often follow oral or



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parenteral administration and will occur at the former site of contact.

The lesion of contact dermatitis may be caused by external application of drugs, or by contact with cosmetics, industrial agents, feathers and animal danders, certain plants, pathogenic molds, clothing, soaps, dentifrices, dentures and metals (especially nickel). It takes about one week to acquire sensitization after the initial contact, but upon re-exposure a sensitized individual may develop symptoms in only one or two days.

Lesions of the intrinsic type are due to the ingestion of allergenic foods, to drugs taken internally or parenterally, and to inhalants. It may seem rather odd to consider the inhalant class of allergens as a cause of dermatitis. However, many allergists and dermatologists are reporting a rapidly increasing number of cases of eczema and other skin lesions in which the cause has been traced to sensitization to house dust, molds, pollens, and other inhalants.

The local symptoms of allergic dermatitis may range in intensity from mild itching and dry flaking of the skin to severe excoriation and ulceration, accompanied by painful swelling and copious weeping and outpouring of serous exudate. Systemic effects, such as general malaise, increased blood eosinophilia, chills, and fever, may accompany and complicate the local reaction and add greatly to the discomfort of the patient.

Someone has said that the diagnosis in aller-

* Presented at the Section meeting on Ophthalmology and Otolaryngology at the annual convention of Indiana State Medical Association in October, 1952.

gic disease is made by scientific investigation—25%. plus good detective work—75%. This is especially true in dermatologic allergy. A good exhaustive history is the most important feature in the examination, both in establishing a general diagnosis of allergy and in ferreting out the particular allergenic substance responsible for the trouble. Some cases can be solved on the history alone. Intradermal tests with inhalant and food extracts are useful in differentiating between various allergens which have been brought under suspicion by the history. Patch tests with other types of allergens, particularly of the contact type, also are of value and will help further in clinching the specific diagnosis.

Common sources of causative agents of allergic dermatitis:

1. Contact type:

- a. *Cosmetics*—creams, lotions, rouge, lipstick, hair dyes and rinses, nail lacquers, perfumes.
- b. *Danders*—feathers, pets, human dandruff.
- c. *Drugs*—penicillin, sulfonamides, sulphur, mercury, antihistamines, local anesthetic agents, antipruritics.
- d. *Plants*—ivy, oak, etc.
- e. *Pathogenic Molds*—trichophyton, epidermophyton, monilia.
- f. *Industrial Agents*—dyes, gums, plastics, lacquers, glues, resins, rubber.
- g. *Clothing*—silk, wool, nylon, rayon, furs.
- h. *Soaps*—detergents, dentifrices.
- i. *Dentures*
- j. *Metals*
- k. *Insecticides*

2. Intrinsic type:

- a. *Foods*
- b. *Drugs*
- c. *Inhalants*

The external ear is probably the most frequent site of allergic dermatitis seen by the otolaryngologist. Sensitization to cosmetics is responsible for many cases of dermatitis of the external ear, and of the surrounding skin, as seen in women. Here the source of contact may be in facial creams, lotions, powders, rouge, etc.,

or in dyes and rinses for the hair and in various other preparations used for waves, sets and so-called permanents and other types of hair-do.

Case Report No. 1

One of my patients, a young man of definite allergic tendencies, developed a severe eczema of the left external ear and surrounding area. The attacks were intermittent and were followed by periods of spontaneous relief. The lesions recurred promptly after "necking" parties with his sweetheart, and the mystery was finally solved when it was discovered that the patient was sensitive to henna, used as a hair rinse by the young lady.

Finger nail lacquer also is a common offender, and comes in contact with the ear in the adjustment of earrings and in many other ways, including plain scratching of an itching ear. Earrings themselves may cause irritation. Sensitization to one's own dandruff may be a factor, or the lesion may be caused by certain drugs used locally in the treatment of chronic middle ear disease.

Case Report No. 2

A young woman consulted me complaining of discharge from the ear which had persisted intermittently in spite of two radical mastoid operations. Sulfonamide powder used in the ear to combat this condition caused prompt local reaction with profuse outpouring of exudate, and swelling, redness, pain and severe excoriation, involving the skin of the canal and external ear. This same result followed the use of sulfa when it was used a second time, for verification. Also, upon another occasion the same local reaction in the ear developed when sulfa was used internally for another condition.

Sensitization to pathogenic molds is occasionally responsible for a very severe, and stubborn form of external otitis, in which trichophyton, for instance, may be transferred to the ear from such infections as athlete's foot. This type of otitis externa may be closely simulated by infection from bacillus pyocyaneus which must be considered in the differential diagnosis. This may be accomplished by cultures and cytologic examination of the aural discharge. The

presence of eosinophiles in the smear examination usually indicates allergic reaction, while a preponderance of neutrophils denotes infection. Other common sources of these allergic lesions of the ear are contacts with feathers, danders of pet animals, rubber bathing caps, silk and wool wearing apparel and furs. Even such a simple thing as lying on a freshly laundered pillow slip may cause much trouble of this sort if the individual happens to be sensitive to the soaps or detergents used in the laundering process.

These same lesions of the external ear and canal may also be caused by sensitivity to foods, to drugs taken internally, and to inhalant allergens.

Allergic conditions affecting the lips, tongue and mouth cannot be classified as dermatologic lesions, of course, but they are not infrequently seen by the otolaryngologist, and it might be well to consider them in this sort of discussion. The lips, the tongue, and the larynx may become quite seriously involved by the swelling of angioneurotic edema. The cause may be sensitization to foods, to drugs or vitamins, reaction to insect stings, or to overdoses of pollen or other allergenic extracts. Sensitization to one's own dentures is responsible for many cases of painful irritation of the lips, gums, tongue and other parts of the mouth. This may also be caused by tooth pastes, gargles and mouth washes, and drugs used locally in and about the mouth.

Case Report No. 3

A fifteen year old boy of allergic background was brought to me with the complaint of recurrent tenderness and swelling of the gums, lips and tongue. The history revealed that these attacks cleared up spontaneously within two or three days and always followed periodic visits to a prophylactic dentist. Upon inquiry it was found that he used penicillin locally each time he cleaned the boy's teeth. After the use of this drug was discontinued the boy had no further trouble of this kind.

Allergic involvement of the eyelids is often seen as a complication of allergic conjunctivitis due to pollen, house dust or other inhalant sensitization, or as contact dermatitis from cosmetics, drugs, cleansing agents, bleaches, or other local irritants of like nature. Spectacle frames,

either plastic or metal (nickel), are a common cause of allergic dermatitis involving the nose, eyelids, brow, face and ears. Intrinsic factors, such as foods and drugs, as well as external contacts, may be responsible for the swelling, crusting, flaking, itching and other symptoms encountered in allergic conditions affecting the eyelids. The area involved may be limited to the lid margins or may extend to the skin about the eyes, face and temples.

Case Report No. 4

One patient complained of much itching, burning, crusting and flaking of the eyelids, present for seven years. A detailed history revealed that the condition had suddenly become much worse a few months before after the patient had slept on a feather bed during his vacation on a farm. Following this clue, feather contact, as in pillows, etc., was removed and the complaint disappeared entirely within a few weeks. This was the only treatment needed for relief, although the patient was known to be sensitive also to several foods and to house dust, cigarette smoke and newsprint.

Many industrial workers are sensitized to certain allergenic materials which they handle in their daily work. Dyes, gums, resins, lacquers, plastics and glue, are a few of the many contact allergens to which they may be exposed. The dermatologic lesions may not appear upon the hands, or fingers, where the skin is relatively tough and more resistant, but may be seen about the face after the individual rubs his eyes or scratches his nose or ears, and thus transfers the allergenic substance to those areas.

Case Report No. 5

An example of this was seen recently in the case of the editor of a trade journal who complained of conjunctivitis and itching, inflammation and swelling of the eyelids. He also suffered from seasonal hay fever and from perennial chronic rhinitis. The history revealed that the eye symptoms had been present for three years, starting soon after he began to work at his present occupation, and that absence from work, as on vacations, etc., resulted in spontaneous improvement. With these clues it was not difficult to trace the cause to a certain kind of cement handled by the patient in pasting up

the galley proofs of his trade magazine. The use of another type of cement resulted in complete recovery.

Treatment of Allergic Dermatitis

- I. Stop all current treatment. Patients often become sensitized to drugs used to alleviate the primary condition.
- II. Prophylactic—eliminate all contact with drugs, foods and contactant allergens known or suspected to be the offenders. This, of course, is the best treatment by far.
- III. If this is not possible, attempts at hyposensitization should be made by injections of an extract of the offending substance, if it lends itself to this type of treatment. Sometimes a certain food is too important or too difficult to remove from one's diet, in which case hyposensitization to the food may be tried. That hyposensitization to food proteins can be accomplished in spite of reports to the contrary and warnings that such procedure is too risky to attempt is shown by the following case report.

Case Report No. 6

A young woman could not eat wheat products without suffering from acute rhinitis, itching, burning and swelling of the eyelids and from acute eczematous involvement of the ears, with swelling, itching and serous exudate. These symptoms developed both upon ingestion of wheat and upon exposure to wheat flour in cooking and at the patient's place of employment. This was in an office directly over a bakery from whose bins flour and dust escaped every day to filter up the stairway and to invade the office where the young woman worked. Her only escape from this exposure was on Sundays and at other times when she was absent from the office, upon which occasions the symptoms improved. Hyposensitizing injections of wheat extract gave the patient sufficient relief that she was able to continue her work in comfort and also was able to eat the wheat equivalent of two slices of bread daily without recurrence of the symptoms.

A major problem is often encountered in trying to banish a child's pet from the household. The psychic response of the child may be a serious complication and is a factor which must be considered in addition to the primary trouble. Here again hyposensitization to the offending allergen may be of great help in solving the problem, as in the following case.

Case Report No. 7

A boy of five who suffered from asthma and nasal allergy due to sensitization to house dust also developed eczematous lesions upon his face and hands when he visited his grandparents and played with their dog. This also aggravated the nasal and asthmatic symptoms. The parents tried to explain the situation, but the grandparents thought the whole idea was silly and refused to get rid of the dog. And so Billy was denied the privilege of going to his grandparents where he had been a frequent and pampered visitor. This situation led to a strained relationship between the two families and to emotional and personality upsets upon the part of the boy, who, of course, could not understand. Hyposensitizing treatment with an extract of dog dander has given Billy enough protection to allow him to resume his visits without the development of symptoms, and everyone is happy again, including the dog.

Hyposensitizing treatment may also be used to good advantage in otitis externa due to pathogenic molds. Dr. French Hansel reports much success in this field through injections of extracts of such molds as trichophyton, epidermophyton and monilia.

- IV. Non-specific treatment such as the use of staphylococcus toxoid has been of help in the control of hives and other eruptions.
- V. Antihistamine drugs used both internally and in ointments and lotions are often of value. However, patients not infrequently become sensitized to these agents, especially if used externally, and a close watch for this complication must be maintained.
- VI. Soothing, antipruritic creams and lotions are often very comforting, but here

again secondary sensitization may develop and complicate the primary condition.

- VII. ACTH and Cortisone. If ACTH is to be used, the Jel preparation is preferred, as it can be given intramuscularly or subcutaneously, either in the office or home, with very little if any reaction.

These two drugs will relieve and control the symptoms of dermatologic, as well as other types of allergic reaction. Their effect is fleeting, however, and they should be used only temporarily for the control of emergencies and severe exacerbations, pending the outcome of the examination and the institution of specific or more logical treatment measures.

**Discussion: Lall G. Montgomery, M.D.,
Muncie**

Doctor Craft has just given us a brief but comprehensive survey of the chief considerations in an important field of allergy, and I am sure has given all of us some new ideas. He has also raised some interesting questions in our minds and I hope that he may have an opportunity to discuss some of them before he closes.

One thing that I would be glad to hear him mention is the differential diagnosis between a bacterial external otitis, a contact sensitivity, and a chronic fungus infection. We have sometimes been hard put to make a clinical differentiation between these conditions, and yet it is important to know which one is dealing with before treatment is started.

Then, too, is it not sometimes true that two or more factors may come into play, such as an eczematoid mold eruption which becomes secondarily infected with staphylococcus aureus?

Another problem is that of differentiating an infectious rhinitis, or other chronic inflammations of the nasopharynx or eyes, and similar lesions which have an allergic basis. How can the family doctor, for instance, tell when to refer a patient for an "allergy work-up" in such cases? I wonder what Doctor Craft would think of the use of French K. Hansel's examination of smears from the discharge of the affected areas for the presence of eosinophils as a basis for a preliminary opinion?

A subject of great interest which Doctor Craft mentioned briefly, is the method of treating allergic patients by the process known as "hyposensitization" which used to be called "desensitization." It is really a subject in itself, but there are a few points that might be mentioned briefly.

For many years we have been using this method in selected cases with considerable success, and have been using the intradermal route in our treatment rather than the subcutaneous or intramuscular routes. We believe that the intradermal route has great advantages, some of which may have been mentioned here.

1.) By giving the injections intradermally we produce a skin wheal and erythema, the size of which may be used to determine the degree of skin sensitivity. Using this as a guide one is less likely to increase the dosage too fast. We also believe that the patients will get along better if the dosage is kept down to a point at which it produces a skin erythema of about 2 cm. in diameter. We have found that giving doses of extracts and vaccines which are too large may not only produce unpleasant reactions, but may actually increase the apparent sensitivity of the patient and render the patient refractory to subsequent treatment. Unfortunately it is often the tendency of the physician when giving a course of injections of this kind, to adhere strictly to a schedule of dosage increases, whereas, we have found the skin reaction produced by the intradermal injection to be the best indication for estimating the size and rate of increase of dosage. Some patients may not need more than a very small highly diluted injection, and will obtain their best results with a minimum increase in the size of the dose. Others may need larger doses and more concentrated extracts. The intradermal reaction will tell the physician how to proceed.

2.) We believe that intradermal injections are less likely to produce unpleasant or dangerous local or general reactions.

3.) It seems to be fairly well shown that small intradermal amounts of extract or vaccine will produce the same beneficial result as a much larger dose given subcutaneously.

I would be glad if Doctor Craft would give us the benefit of his wide experience in the use of hyposensitization treatment.

One thing that Doctor Craft did not have time to mention but which I would like to bring out is the importance of choosing the right time to have patients skin tested. All too often the family doctor is under severe pressure from the patient and the family because the patient is having a severe itching skin lesion or angio-neurotic edema and they all want something done "right now."

We sometimes have patients in this condition brought in by ambulance, apparently with the idea that the skin tests will solve the problem in a hurry.

Of course such is not the case, but the serious part of it is that the skin tests may actually be entirely negative in this stage because of the widespread skin lesions.

Another problem in these cases is that they have often been given various kinds of antihistaminics or adrenalin or ephedrine for symptomatic relief, and while under the influence of this treatment the skin tests may be modified or

entirely negative, whereas, after the acute attack is over the skin tests may be markedly positive.

If we have the opportunity we try to persuade the patient to let the family doctor administer symptomatic treatment, and send the patient in for possible testing when the acute attack is over. Of course, if the attacks are very protracted one can resort to such a difficult procedure as passive transfer testing, but that is probably too large a subject to enter our discussions now.

I would like very much to have Doctor Craft give us some advice on how the family doctor can best help to tide a patient over the acute attack.

This has been such a stimulating paper that I am sure we could continue our discussion indefinitely, but we will have to limit ourselves to a few of these points that have been mentioned. It has been a pleasure to take part in this very interesting and timely paper.

* Length of papers prevented Doctor Craft from answering some of the questions raised in the discussion.

TREATMENT OF RENAL CALCULI

The authors feel that more attention needs to be paid to the etiology of renal calculi, especially with the high incidence of recurrent stone formation. Among factors which they mention are vitamin A deficiency, hyperparathyroidism, increased calcium excretion, infected urine, focal infection, urinary stasis, gout, pregnancy and the effect of recumbency. Surgical management is well discussed but the point is stressed that surgery is only one phase of the management of the problem of a patient with a renal stone.

Wattenberg, C. A. and Beare, J. B.; Renal Lithiasis and Recent Concepts in Treatment. *J. Kan. Med. Soc.* 54:256. June 1953.

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MEDICAL CIVIL DEFENSE

ATOMIC WARFARE differs from other types of warfare in that almost all its preparations must be made in advance. After atomic warfare starts one tends to become less ready rather than more ready. This observation applies particularly to defensive preparations, and more especially to medical defense.

Americans have made most of their preparations for war after the wars have started. The next war, if it comes, will be different. The next war will be fought with what is on hand when it starts. There will be little time or opportunity to manufacture anything, or to do any training either for offensive or defensive action.

With this in mind, it is well to review the plans and preparations for medical civil defense in Indiana. These plans are being revised at regular intervals. The entire problem of defense against atomic warfare is amazingly complex. All elements of the complicated plan, including the medical part, must be integrated with each

other. As the state and county planning has developed, the various parts have been revised so as to make them dovetail and thereby increase efficiency.

Since the exact disaster conditions cannot be predicted, the plans must be made on a flexible basis. Everyone should know what his primary assignment is in event of a catastrophe, and he should also have several alternatives. Plans should be constructed so that all personnel are able to proceed with their assignments without further instructions.

As important as the assignment and utilization of medical and auxiliary medical personnel is the problem of medical supply. Many of the items required for emergency treatment may be improvised. However, some of the most important items cannot be improvised and must be obtained beforehand.

Medical supplies should be stored far enough away from the center of a target area to prevent their destruction, and close enough to make

them available on short notice. The remainder of the medical stock pile may be stored well away from target areas and located so that it can be dispatched to any one of several target areas.

One of the large Federal Civil Defense warehouses is in Indiana. It now contains some seven million dollars worth of medical supplies, and in the near future may acquire an additional four million dollar stock. It is designed to furnish the third echelon of supplies to target areas in eight middle western states.

Its supply level is illustrated by the fact that it now has about a half a million blood donor sets and almost as many transfusion sets. It has almost 1.5 million first aid dressings, 41,000 knife blades, 20,000 needle holders, and approximately 40,000 bandage scissors. The incompleteness of the supply status is shown by the fact that no tetanus antitoxin is stocked and there are no litters, no blankets and no blood grouping sera. These, and a few other vital items must be acquired before the depot can be considered as ready.

It must be pointed out that this stockpile would furnish the third echelon supplies for reinforcements to Indianapolis, Detroit, Chicago, Milwaukee, Minneapolis, St. Paul and at least twenty additional target cities. First and second echelon supplies for immediate utilization will need to be near the areas likely to be bombed.

The close-in medical supply for a target area may be illustrated by the Indianapolis plan. Supply kits, designed for the first-aid treatment of 600 to 1,000 casualties, have been assembled by the State Department of Civil Defense. The bulk supplies are obtained by states and counties on a fund matching basis. Indianapolis is supplied with 36 of these kits. They are stored on the periphery of Indianapolis in 16 different well protected places. Except for those items of supply that may be obtained from undamaged hospitals, drugstores, physicians' offices and homes, these kits will constitute the first echelon supply and will be available as soon as the sup-

plies can be transported to medical treatment stations.

In addition to the 36 kits being stockpiled by the Indianapolis civil defense organization, 15 Indiana counties have purchased a total of 120 kits for their first echelon supplies. Some counties realize that they are not probable targets but have stockpiled supplies to enable them to contribute to the casualty services operations in a neighboring stricken county.

The State Health Services Division of Civil Defense has 25 units in state storage dispersed in two points in strategic locations safely removed from targets. These kits may be considered as second echelon supplies and would reinforce the supplies stored near likely targets.

The importance of organization and assignment of medical and auxiliary medical personnel in civil defense in all Indiana counties cannot be over-emphasized. If Indiana were hit in a saturation type bombing in which more than one target city were hit with atomic bombs, the number of casualties resulting would require that pre-planned and organized medical teams from almost all counties be ready to support the bombed cities. Indeed their survival might depend upon this. This is an entirely new conception of defense by civilians. The new casualty producing potential of atomic weapons makes it necessary that we plan to utilize almost all of our human and material medical resources in all Indiana communities for a Civil Defense. This requires laborious and sometimes thankless planning by the medical profession in all communities.

Medical leadership and the responsibility for medical civil defense planning belongs to the entire medical profession in all Indiana counties. Much civil defense planning has been accomplished, but it must be remembered that if America ever gets involved in another global war our military authorities assure us that Indiana communities will be hit. Our citizens will be the targets. Caring for the thousands of injured will be the task of the medical profession augmented by the auxiliary health professions. Needless to say, the physician must be the leader. Now is the time for organizing, training and planning our defense.

MEDICAL REFERENCE SERVICE

THE Medical Library of Indiana University School of Medicine is announcing the expansion of its reference and loan department, and the provision of its facilities for the medical profession of Indiana.

Details of the expanded service and of the mail service included with it appear elsewhere in this issue of *THE JOURNAL*. The library, through its Reference Librarian, will be able to furnish medical literature surveys and bibliographical work on specific subjects, in addition to its loan service by mail or in person.

The School of Medicine recently has increased the floor space of the library. The addition of much needed stack room and the provision of facilities for library research have improved the physical plant and made its operation much more efficient.

At the present time approximately 50,000 reference volumes are catalogued and available for loan.

The primary function of the library, of course, is for the advancement of undergraduate education. Its secondary and equally important function, that of graduate and postgraduate education, has been recognized by the University, and is fulfilled by its service to the practitioners of the state.

Current periodicals constitute the most important part of medical literature. It is in this department that the I. U. Medical Library is especially strong. An almost complete coverage of important current literature is available.

Indiana University is contributing greatly to the practice of medicine by making its medical library available for use throughout the state.

NARCOTIC SUPPLIES

FROM time to time there have been published in *THE JOURNAL* statements on the responsibilities of physicians under the Harrison Narcotic Act. In addition to having a registry number that must be renewed each year, the practicing physician must exercise control over his supply of narcotics if for no other reason than to protect himself. In the same light, pharmacists and drug wholesalers must observe certain responsibilities if they are to avoid difficulties with the Federal Bureau of Narcotics.

Physicians cannot obtain nonexempt narcotics directly from pharmacists (unless they are registered as narcotics wholesalers) for use in their offices; they must obtain official order forms to secure narcotics for their practice. They can, of course, prescribe narcotics for patients and expect such prescriptions to be filled at pharmacies and in hospitals. However, an interesting aspect of the prescribing of narcotics concerns the liability of the pharmacist, who is responsible

under the federal law for determining if the prescription was written by a physician (or other authorized practitioner) and who thus must always be on the alert for forged signatures and for prescriptions that have been stolen. When in doubt the pharmacist should consult with the physician whose signature appears on the prescription and when he takes such action he is not being arbitrary but rightfully cautious.

A narcotic order received by telephone cannot be delivered until the pharmacist or his manager receives a written prescription. The prescription cannot be mailed or delivered later. Furthermore, a narcotic prescription cannot be refilled; nor can it be signed by anyone other than the physician, who must sign, not type or stamp his name. He cannot even ask his nurse to sign for him. Nor can he sign several blank orders and leave them with a pharmacist to be used later as the need arises. Each prescription must contain the date on which it is written,

the full name and address of the patient, and the name, address, and registry number of the prescribing physician.

Physicians are likely candidates for addicts to approach in the hope of obtaining narcotics or an order for them by one trick or another. The excuses offered in the average doctor's office are almost too numerous to mention, but nevertheless the physician must always exercise his best judgment to detect such falsified tales if he wishes to avoid innocently coming into conflict with the law. In addition, his car if recognized as belonging to a physician may be broken into by addicts looking for narcotics; or his office may be ransacked. Or he may even be held at gun point by the more desperate. Regardless of the method of attack by an addict the doctor must account for his narcotic supplies, and it may even be wise for him to keep his narcotics divided for hiding in several places. At all times they should be kept under lock and key.

There are comparatively few honest persons who would deliberately invite trouble by carelessly handling narcotics. There are others, however, who risk embarrassment and misunderstanding because of thoughtlessness or even ignorance of good practices. The safeguarding of narcotics is a responsibility of several interested groups—doctors, pharmacists, drug wholesalers, drug manufacturers, and law enforcement officials. Each usually tries to use common sense and to respect the laws. On occasion there may be an unintentional slip, and when such occurs a tolerant attitude can be taken only when there is evidence of unquestionable good faith on the part of the offender. Thus it behooves everyone to appreciate not only his own responsibilities but the problems of others who are involved in the handling, use, and control of narcotics. It is too serious a problem to permit impatience and intolerance.—The Journal of The American Medical Association.

ADVANCES IN THE TREATMENT OF GOUT

Warter refers to study showing that a high blood uric acid level is transmitted as a Mendelian dominant characteristic. The point is made that gout may kill from cardiovascular or renal damage in the absence of any history of joint distress. The diagnostic value of x-ray films of the joints is stressed in diagnosis as is the level of the blood uric acid and the finding of urates by chemical methods in tophi. Details of the use of ACTH, colchicine, and Butazolidin in acute stages is well presented. Long term treatment of gouty patients with Benemid is likewise well covered. Personal experiences with the intra-articular use of hydrocortone acetate is presented. Warter sees no necessity for dietary restrictions except for associated conditions.

Warter, Peter J.: Advances in the Treatment of Gout. J. Med. Soc. N. J. 50:328, August 1953.

YOUNG POSEYVILLE DOCTORS FIND REAL SATISFACTION IN SMALL TOWN CLINIC

"We are both happy here and are very much surprised at the number of patients we have," Dr. Carroll L. Boyle told THE JOURNAL recently when queried three months after he and Dr. Ivan Gailey opened their clinic in Poseyville. Poseyville is a little town of about 1,000 population near the southwestern tip of Indiana.

Prepared for a lean year or two, Doctor Boyle, who is 31, and Doctor Gailey, 30, agree that "response is much better than we had expected." Since opening their 11-room clinic on July 15 they've seen an increasing number of patients each month.

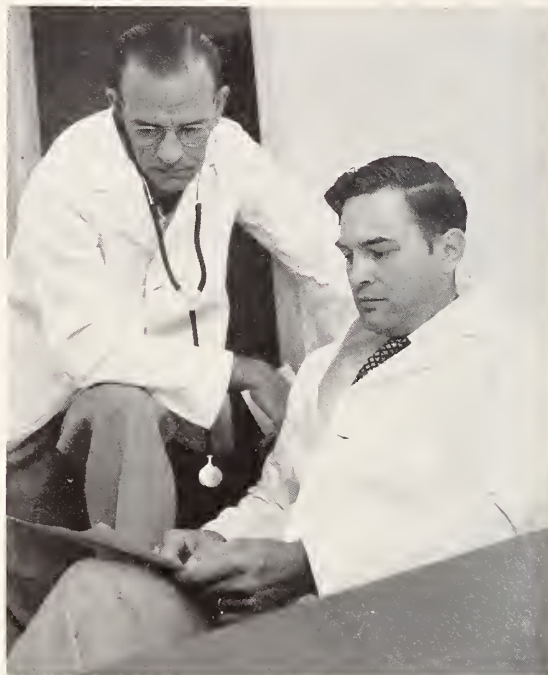
The clinic has been named The Walter Struve Clinic in gratitude to Doctor Boyle's father-in-law, who has given them substantial financial aid. Those funds, in turn, have been augmented by civic-minded residents of the Posey county community who have helped in many ways to assure adequate medical services for that area.

The Struve Clinic is located in a remodelled building which was constructed for use as a store in 1946. A glass brick front has been installed, 11 rooms created for consultation, treatment, examination, laboratory and x-ray. One room is equipped for overnight use in case of an emergency, although the young Poseyville doctors plan to use Evansville hospitals, 27 miles away.

Doctor Boyle is a native of Poseyville, 1939 graduate of the high school there and a 1952 graduate of Indiana University School of Medicine.

Doctor Gailey is a native of Salt Lake City and a graduate of Albany Medical College, Albany, New York.

Both doctors have realized life ambitions to enter the medical profession and both returned to medical school after serving during World



Dr. Carroll L. Boyle, left, and Dr. Ivan Gailey discuss a case history of one of their patients at the Walter Struve Clinic in Poseyville. Like many other young veterans the two doctors, who became acquainted while interning at Gary Methodist Hospital, are finding a definite place in a small community. There is the satisfaction of practicing their profession where they are needed, and of providing a home for their families in a friendly Indiana town.

War II. Doctor Gailey was a pilot, Doctor Boyle a navy radioman, and each served more than three years. They interned last year at Gary Methodist Hospital.

Mrs. Boyle is a native of Superior, Wisconsin; Mrs. Gailey comes from near Pittsburgh. The Boyles have an 18-month old daughter; the Gaileys a seven year old son.

Although they came to the small Indiana community through personal connections, Doctor Boyle and Doctor Gailey are fully cognizant of the truth of the slogan of the Physicians Placement Service of the Indiana State Medical Association which reads, "A Place of Your Own Is Awaiting You in Indiana."



Various factors during pregnancy (intestinal displacement, atony, inactivity) make it virtually impossible for most women to go through the gestation period without constipation.

CONSTIPATION IN PREGNANCY: *Satisfactorily controlled with Metamucil®*

Metamucil, with its physiologic principles of "smoothage" and "normo-hydration," is well tolerated for pregnancy constipation. This bland vegetable colloid may be used throughout the entire nine-month period without fear of forming a "habit" and without irritation to the mucosa.

Greenhill¹ suggests that Metamucil be given every other night. He also recommends that Metamucil be given in conjunction with a proper diet,

during the lying-in period of the puerperium.

Metamucil is the highly refined mucilloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

1. Greenhill, J. P.: Principles and Practice of Obstetrics, ed. 10, Philadelphia, W. B. Saunders Company, 1951, pp. 103-104; 311; 332.

SEARLE Research in the Service of Medicine

PRESIDENT—1953-54

Indiana State Medical Association



WILLIAM HARRY HOWARD

Hammond

William Harry Howard, M.D.
President
Indiana State Medical Association
1953-54

DR. HARRY HOWARD, of Hammond, succeeded to the presidency of the Indiana State Medical Association on the last day of the 1953 Annual Convention, and was installed as president during the after-dinner ceremonies on October 21.

In his speech of acceptance, Doctor Howard used as his keynote, "Hoosier Physicians Meet the Need". A partial list of the objectives for the coming year was outlined. Each of these programs is under way and can be pointed to with pride, he said. His promise to the public is that Indiana doctors will continue to recognize their obligation to provide Hoosiers the best medical care, and will strengthen their activities to assure realization of this goal.

Doctor Howard was born in Remington, Indiana on November 28, 1895. His early schooling, including high school, was obtained in Remington schools. After service in the U. S. Navy during World War I, he attended Indiana University and received the B.S. degree in 1920, and his M.D. degree in 1922.

He served a rotating internship in the Indianapolis City Hospital, and completed his training in the same hospital with a two year surgical residency. In 1925 he opened an office for the practice of surgery and gynecology in Hammond and has been an active member of the profession of that city ever since. He is a fellow of the American College of Surgeons.

Doctor Howard is married and has three children. His oldest son, William F. Howard, is a senior medical student at Indiana University School of Medicine and his younger boy is a freshman pre-medical student. He has always taken more than the average amount of interest in civic affairs. He is a member of the Hammond Chamber of Commerce and the Orak Shrine.

He is past-president of the Lake County Medical Society. He has served his county society in numerous other capacities, one of the most important being the chairmanship of the committee which planned the reorganization of the society and employed its first full-time executive secretary.

Doctor Howard was particularly active as Councilor from the Tenth District from 1943 to 1952. During this period he was especially interested in the formation of Mutual Medical Insurance, and was chairman of the Permanent Study Committee on Health Insurance in 1944, and was a member of the Committee on Prepayment of Medical and Surgical Care in 1945. He is at present vice-president of Mutual Medical and is a commissioner of the National Blue Shield Medical Care Plans.

He served as vice-chairman of the Surgical Section of the State Association in 1943 and was chairman in 1944. He was a member of the Committee to Study Cultists and Irregular Practitioners in 1941, 1942 and 1943. He was a member of the Council on Medical Service and Public Relations in 1945 and 1946. He also was on the Medical Economics Committee in 1945 and was its chairman in 1946.



President's Page



DEAR FRIENDS:

ANOTHER year and another President but the old Indiana State Medical Association rolls merrily along.

I want to thank the delegates and my friends who are not delegates for their trust in me by electing me to this office. All I have to say is that I appreciate it and will do the best that I am able to do.

Many of my committee appointments are out and in the mail. I have placed several of the younger men on these committees. Up until a short time ago I felt that I was one of the younger men, but when the son-in-law of one of my golf partners substituted in our foursome, he remarked to his father-in-law in telling about the game—"The old Doctor plays a pretty fair game of golf". That sort of thing puts us in our place.

Seriously, the medical society needs the young men to take an interest in organized medicine. It is they who will be affected by the inroads of socialism or any let-down in the practice of medicine as we have known it.

As another of my friends said the other day, "It was more fun when we sat on the back seat and scoffed."

The following is in part the report of Hospital-Physician Relations Committee which was passed by both the American Hospital Association and the American Medical Association.

"The professional evaluation of chiefs of service and members of the medical staff should be the responsibility of the medical profession. The method of selection of these individuals must be subject to local arrangement and local conditions. In any such arrangement, however, the principle of the freedom of the staff to make recommendations subject to approval of the hospital governing board, should be recognized."

This is fine as far as it goes. Do you have any ideas as to what we, as a Medical Association, can do about it?

Wm Harry Howard M.D

SQUEEZE THE LEMON, LET THE JUICE SQUIRT WHERE IT MAY*

President-Elect Howard, Members of the Indiana State Medical Association, The Auxiliary and Distinguished Guests:

In "Tam O'Shanter" you will find this line: "Nae man can tether time and tide." Burns could have said "Nae man can tether time, tide, and 'the Presidency of the I.S.M.A.'" So, this evening is set aside for the rendition of an address which is presumed to ease the inevitable passing of the President. And if you apologize to Julius Caesar, "Actually you have come here to bury the outgoing President, not to praise him" knowing full well that "The evil men do lives after them, the good is oft interred with their bones." Gerontologically speaking, each President, at the end of his term of office, begins to inquire about ways and means to increase his longevity. Well, the relief from the responsibility of this office, an honor though it be, is a great boon to his constitution. He receives further therapeutic aid if he ceases the use of nicotine, discontinues alcoholic indulgences, and refrains from doing what the Kinsey report says people do do. You ask, does such abstinence prolong life? No, ladies and gentlemen, the abstinence from these gratifications will not prolong life, but it will make life seem to be very much longer. In his valedictory address at Johns Hopkins in 1900, Osler recommended an overdose of chloroform for all men at age 60. Had Osler been familiar with our Ponce de Leon pharmacopeia, he might have considered age 75 as an age for uselessness in Hoosierdom.

During the past year, by necessity rather than by proclivity, I have attempted to discuss in private and in public some of the problems confronting organized medicine. Most of my remarks have been relegated to the cemetery of discarded oratory where, along with the utterances of preceding Presidents, they lie buried side by side. After all, words alone do not propel a physician into tithing his time for organized medicine. Physicians long have been noted

Paul D. Crimm, M.D., Evansville, climaxed a long career in organized medicine during 1952-53 when he served as President of the Indiana State Medical Association. A native of Ohio, where he was educated, he has been a resident of Indiana for 25 years.



Crimm

as men invincible at the bar, but invisible when there is medical organizational work to do. However, if someone else does the work and accomplishes the results in spite of odds, they are kind enough to emulate Charles II when he said, "I always admire virtue but I never could imitate it." Nevertheless, there is no greater fraternity than the fraternity of those who follow the art and practice of medicine in a manner that speaks for honor, truth, and dignity, with which any Hippocratic disciple is quite familiar. All of us are cognizant of a few chiselers in our ranks. But in this connection, I am reminded of the words of Joaquin Miller,

"In men whom men condemn as ill
I find so much of goodness still;
In men whom men pronounce divine
I find so much of sin and blot,
I do not dare to draw a line
Between the two where God has not."

An improved method of eliminating chiseling characteristics might be instituted by bestowing responsibility upon the wayward practitioner. Give any disgruntled practitioner of your county society a committee assignment and a transformation of his attitude often transpires. Nothing can be substituted for accurate information, argument, and an interchange of ideas to "calm the troubled waters." Every local medical society

* The address of the President of the Indiana State Medical Association, presented to the One Hundred and Fourth Annual Session, French Lick, Indiana.

has a great responsibility to each member, in that it should offer its members an opportunity to discuss the social and economic problems which face organized medicine today. The American Medical Association, the Indiana State Medical Association, or your local society is not just a service or a scientific organization. They are advisory organizations; advisory to patients and to the public on matters of patient health and community welfare. In order to be capable of acting in this capacity, all social and economic problems related to medicine should be discussed at regular meetings and all absentees should be urged to read *THE JOURNAL* of the Indiana State Medical Association, an excellent periodical, to keep abreast of the times. If time at your local and all district meetings is not allotted, your delegate and your councilor attend state meetings and council meetings without your views on current problems. Too often, problems are presented, some necessarily so, to your executive committee and council, and are acted upon without ascertaining the opinions of the majority of the county societies. A commendable intra-organization example of how opinions can be obtained happened when the Executive Committee and the Council recommended to the interim session of the House of Delegates that the interim sessions be discontinued. The House resolved that a poll be taken of the county societies as to their opinion. The county societies, including those located in the largest centers of population, voted overwhelmingly in favor of its discontinuance. And the 1953 session of the House of Delegates has access to the will of the majority and may conclude that the interim session, born in a spirit of helpfulness, should be abjured with an appropriate literary requiem, as in Bryant's "Thapatoopsis"—"that endless desolate waste of nameless days."

Opinions on extra-organization affairs are not so easily obtained, and effort should be made to study thoroughly the programs of other groups which desire support from the Indiana State Medical Association prior to endorsement or rejection. An example of this occurred when the Council and House of Delegates sanctioned the contents of a public health bill in 1951. This bill was endorsed because of lack of study and had the full implication of the bill been sent to the county societies for study, it could have been revised. As it was, the "grass roots" support was

solicited after this unfair bill was in the hopper of the legislature. Fortunately, it was defeated. This bill would have centralized more control of local health departments with the State Board of Health, because it would have provided the State Board of Health with money to distribute not just to counties where new health departments were to be created, but to health departments in cities which were able to raise sufficient tax monies. There is no reason why Evansville, Fort Wayne and Indianapolis, for example, should receive extra tax monies which are earmarked for new health departments. Of course, it is easier to pass a bill if everyone "gets a take" politically. This is not right and support for an unjust bill is gained too often through sympathy and not sound judgment. This bill should have mentioned part-time health officers, since full-time officers are not available. Everyone agrees that we should have full-time health departments, but half a health department is better than none. On the other hand, it is impractical for each county in Indiana to have a separate one. The cost is prohibitive, and several counties will need to combine in order to have such a service. A population of not less than 50,000 might be considered big enough for a department. A bill which would raise money locally to support a local area should provide for the monies to be spent locally. If they need supervision and counsel of the State Board of Health, and if the State Board of Health needs monies for salaries or personnel, then let taxes be earmarked for same. To ask that a bill be passed with this in view, under the guise of creating new county health departments, is political chicanery.

The next session of the legislature will be presented with bills on Public Health, "give-away" programs for nurses' education, Workmen's Compensation, Chiropractors, et cetera. During the ensuing year of 1954, these and other matters should be discussed by your county societies, by the Auxiliary to the I.S.M.A. under the direction of the legislative committee in order that intelligent and concentrated action can be instituted at the opportune time. "Procrastination is the thief of time" and certainly it is not politically expedient.

An issue which must be analyzed by your county medical society is the one which involves the medical care and hospitalization of our war

veterans. The American people and Congress have recognized the fact that disadvantaged veterans represent a group of individuals to which we owe medical care and hospitalization. However, there has developed a divergence of views regarding the classifying of the veteran who has a non-service connected disability, with our group of handicapped veterans. The American Medical Association differs with the American Legion as to who qualifies for medical care and hospitalization. In fact, the rank and file of physicians, and especially those of us who have served in the Armed Forces, do not believe that a veteran who has escaped mental and physical disability during military service is entitled to medical treatment any more than any other citizen who did his bit during the war in industry or on the farm. Up to now the American Legion believes all veterans are a privileged class. However, they stated at the 35th annual convention in St. Louis that the responsibility of the Federal Government is demanded only when veterans are in need, or are sick, broke, and have no place to go. This narrows the divergence of opinion between two great organizations which divergence is a healthy symptom of democracy. In passing it should be noted that many veterans are sick, broke, and have no place to go because of their own irresponsibilities.

This entire problem must be discussed before the American public with all its merits and demerits because they represent the third party who must pay the taxes to the Federal Government ("He who pays the piper calls the tune.") Since the top policy makers disagree as to whether non-service connected veterans should be entitled to medical care and hospitalization, it is the duty of state organizations of the medical profession and all veterans' organizations to work out a solution. For quite some time the State of Indiana has had a voluntary committee representing the veterans' organizations, the hospital association, and the dental and medical associations. This committee has made great strides toward ironing out differences of opinion, and correcting the flagrant abuses which have developed throughout the Veterans Administration. During the next year this committee will continue functioning and perhaps by the next annual convention of the A.M.A. and the American Legion arrive at suggestions for a mutual national understanding. It is the responsibility

of these two groups in the State of Indiana to develop a strenuous educational program regarding the true facts of veterans' programs and the abuses developed many times by administrators. Both the veterans' organizations and the medical profession realize that chiseling on the part of the veterans should be stopped. But, one cannot condemn chiseling on the part of veterans unless one condemns chiseling on the part of the average citizen. It is no wonder that the veteran chisels when, conservatively speaking, 50 percent of our American citizens will chisel if they get a chance to either save a dollar or make a dollar. There are too many people who are out to beat the government rather than help the government save money. It has been stated that two percent of veterans receiving medical care can be classed as chiselers. Statistics, however, fluctuate with the investigators' point of view, which has a tendency to influence figures. In my opinion, two percent is far too low since 75 percent of those citizens admitted to Boehne Tuberculosis Hospital in Evansville during the past 25 years could be classed as chiselers or would-be chiselers, regardless of whether their indemnificatory benefactor is the Federal Government, the county government, or an insurance company. Accuse me of sesquipedalianism, if you like. Members of the medical profession are prone to help veterans and non-veterans chisel and the first place to correct the faults of the Veterans Administration is with the physicians both in and out of the organization. Administrators and physicians in the Veterans Administration are eager to make a statistical showing at government expense, which they would not tolerate if they were spending their personal funds. Even hospitals chisel and if Blue Cross, the hospital's Santa Claus, ever files for bankruptcy it will be because some hospitals are gouging their insurance company by padding patients' bills, which is contrary to what their administrators are taught in their pews on Sunday. "Things have come to a pretty pass" when a patient trusts his life to a hospital which cannot be trusted with a blank check which is to be signed by Blue Cross or any other insurance company. What the average American community needs, along with this campaign of education which the medical profession in the State of Indiana is about to present, is an accompanying campaign of "honesty-is-the-best-policy"ism. We have all been talking about

Americanism as opposed to Socialism and have overlooked the fact that Americanism cannot progress unless it is line-backed by honesty in the home, in the church, and in all fraternal, business, and professional organizations.

More Business Than Service

Sad but true, the Veterans Administration and its hospital organizations have developed themselves into a business rather than service organizations. They are in competition with non-government hospitals and infringing upon the practice of medicine. They are practicing socialized medicine for a segment of our society. Not only must we keep the Federal Government from getting into further hospital business, but we must endeavor to relieve the government of one hundred separate types of business enterprises into which it has invested over forty billion dollars. During our recent campaign against socialized medicine we found most veterans opposed to this program and once the facts are analyzed, no doubt, they will oppose a similar program which is running rampant throughout the Veterans Administration. In the Preamble of the Constitution of the American Legion, it states that we associate together for the following purposes, among which are "to combat the autocracy of both the classes and the masses; to make right master of might; and to transmit to posterity the principles of justice, freedom, and democracy." The medical profession and most veterans' organizations have opposed socialized medicine for the masses. If both are consistent, both should oppose socialized medicine for any particular class of citizens.

Those who managed the Veterans Administration are responsible for the abuses which have arisen in the administration of medical care and hospitalization of veterans even though the law has its faults. No matter how good or bad the law, the administrator of a Veterans Hospital is or is not sympathetic to the advance of Federal Medicine. As a hospital administrator, I have had numerous opportunities to advance or throw cold water on socialized medicine, even with the laws which are on the Statutes of Indiana today. It is astonishing to think that in a free America not until this year has anyone, other than a biased group, been able to consult with the Congressional Committee on Veterans' Medical Affairs. Certainly, this is not democratic and

should cause the rank and file of any veterans' organization to realize that our democracy will fall like the Roman Empire if class against class, the have's against the have-nots continue in needless domestic disputes.

The cost of medical care and hospitalization for non-service connected cases will be too much of a burden for the taxpayer, veteran and non-veteran alike. On August 1, 1953, approximately 65% of the 104,596 veterans in government hospitals were patients with non-service connected conditions. During the preceding year 85 percent of the more than half a million veterans treated in government hospitals were patients with non-service connected conditions. Should a veteran with a service-connected disability for flat feet be hospitalized and treated for a non-service connected broken arm which occurs 20 years later? Here is the problem. There are 20,000,000 veterans in civilian life and this number is increasing by about 1,000,000 a year. In 1970, the number of living veterans, age 45 or over, will be more than three times what it is today and the number over 65 years of age will be ten times greater than today. Naturally this will increase the number of patients who can obtain free medical care for an illness or injury which has no relation to military service. Thus, we face a tremendous increase in the number of hospitals and the cost of Veterans Administration as a whole. The medical profession, which is closely connected with the entire situation, desires to have the entire citizenry study this problem on a factual, and not a sympathetic, basis. This problem also includes the competition of the government hospital system with the state, local, and private hospital. The present shortage of technicians, nurses, and doctors is due largely to their employment by the Veterans Administration. If this program continues it may pave the way for the entire hospital system to be enveloped by the Federal Government. Future generations will be taxed for a specialized group just as the whole United States would have been taxed in a Federal Medicine program for all. It seems to me patriotism ceases when any citizen must pay for hospital and medical care of another citizen who did not acquire a mental or physical disability while a member of the Armed Services.

Grover Cleveland, in December, 1886, said, "When more of the people's sustenance is

exacted through the form of taxation than is necessary to meet the just obligations of government and expenses of its economical administration, such exaction becomes ruthless extortion and a violation of the fundamental principles of free government." Robert Taft said, "If 30 percent of your income is expended for taxes, then you have socialism." One means of heeding the warnings of these two great Americans is to see that more tax dollars are spent in your own county and state. One tax dollar will go three times as far if spent locally than if spent by the Federal Government. If the non-service connected indigent requires treatment, certainly he can be taken care of for less money at home.

Burden Grows Constantly

Many physicians are veterans and although accused of so doing we are not discussing this issue for the sake of political or personal gain. Our interest not only lies in correcting the abuses of the Veterans Administration, which interferes with the American system of free enterprise, but in telling the public of the staggering financial load with which the present method of veterans' hospitalization and medical care will burden the taxpayer eventually, when less than half of the male population will be paying for the medical care of the larger group.

Gentlemen, there are many other social and economic problems with which your county and state societies should familiarize themselves. Each member is in a position to discuss them with patients and with the public in behalf of America and not in behalf of self or pelf. In the United States, we are supposed to enjoy the freedom of speech, whereby the facts which one possesses at any particular time, allow one to express certain frank opinions, whether they be right or wrong. And most of you feel free to exercise this privilege in private conversations, in some committee meetings, in your own home, and especially when one foot is on the bar rail, but elsewhere a certain degree of restraint is deemed necessary in behalf of either self-protection, or for the sake of the issue in question. You, as citizens, are not entirely responsible for a sub-rosa method of enjoying your freedom to speak. You do this because the freedom to say what you think brings about misinterpretations, as well as verbal repercus-

sions. In Russia, if you are rash enough to believe you have the freedom to speak your mind, you are committed to a concentration camp, but in the United States, a supposedly free country, you are spotted for either retaliation with whom you disagree, or you are by-passed politically instead of reclaimed, like the mother who found her five year old boy covered with tar from head to foot said, "It's a heap site easier to have another one than to clean this one up." Recent political campaigns present a fine example of what I have mentioned and the lack of sportsmanship has reached a new low in a country which has always been noted for good sportsmanship. If a gentlemen's agreement between political parties could be obtained, whereby each side would debate the issues involved, instead of maligning each other, it would set a fine example for all organizations who delve little or much into the field of politics. Whether we receive retaliation or not, we should make every effort to have the Bricker Resolution passed by Congress, because a treaty with any nation supersedes any law that Congress might approve or reject. If Congress rejected National Health Insurance a treaty with other nations of the world would force this social monstrosity upon the United States. The United Nations was organized to promote peace in the world, but they waste their time meddling into the domestic affairs, and if they continue the United Nations will "goeth the way of all flesh" like the League of Nations. The politics which concerns the medical profession resolves itself directly in the field of public relations. Organized medicine has come a long way recently in correcting our deficiencies in this department by the appointment of active grievance and public relations committees. Organized medicine the country over is spending money in behalf of good public medical relations. The large public relations spenders are California, which spends \$100,000 a year on just public relations; New York, which spends \$101,000; Michigan, \$100,000 plus; Pennsylvania, \$45,000; Illinois, \$40,000; and Wisconsin, \$30,000. An annual budget of \$15,000 for the newly created Indiana Community Health Council should be considered by the I.S.M.A. We should own a permanent home in Indianapolis. It is much easier to purchase one by means of dues than by subscriptions. In this way, everybody gives and no one shirks a

donation. Two hundred and fifty thousand dollars will be required for this project. We should establish a revolving loan fund for medical students of from fifty thousand to one hundred thousand dollars. We have employed a second field man for northern Indiana and a second attorney-at-law. These are big reasons why we should not decrease our dues.

During the last 12 months, we have spent little money on public relations because we have been investigating and endeavoring to find a project which would yield the most for the limited money to be expended. Our Rural Health Committee has been studying community health projects according to a plan promulgated by the A.M.A.'s Rural Health Committee. However, they proposed a somewhat different set-up, which is an improvement over the A.M.A. plan. Our plan provides for the representatives of physicians, hospitals, dentists, nurses, pharmacists and veterinarians to form a group to be known as the Indiana Foundation for Health. This group of allied professions, who are the only people scientifically trained to administer a health program, would guide the project. There could be a group of 18 directors who would act as the controlling body. Then each county or community would form a local council to be made up of representatives from all organizations such as civic clubs, lay-health organizations, labor, industry and governmental agencies like the local Board of Health, etc. They would have an official representative who would coordinate their work with the state organizations. In this way the allied professions would be ready to advise and guide all the health problems which arise in any community. If a community requires nurses, doctors, hospitals, or any health and welfare assistance, this group would be in a position to advise and start proceedings to obtain the same. These groups could correlate the many sedulous and uncoordinated efforts for health protection which now exist in all communities. Why do this? First, it is becoming popular for all organizations to organize health councils; the professions should accept leadership in this effort so these problems might be worked out on a mutual basis. Second, we will be better able to serve our communities in a systematic fashion. It will save us all time. It will do away with a lot of committees in the allied professions. "United we stand, divided we fall" and a group

like this presents an organization through which we can improve our public relations at the grass roots and in the last analysis protect the practice of medicine as a spoke in the wheel of free enterprise. This will cost money, but it will not increase your dues. If we had had an organization like this in operation three years ago, we would not have employed Whitaker and Baxter for "a flash in the pan campaign." We demand a continuous campaign year in and year out.

May Need Reorganization

Subversive outside influences are compelling us to retrench, to reorganize on a business basis, and to manage our operations more efficiently. The average doctor is a notoriously poor politician, which accounts for many of our larger medical societies employing executive secretaries. It may be that our districts should be reorganized so that they could employ executive secretaries. If not, small societies should either join larger ones or band together for the sake of efficiency and progress. This will increase the dues but what physician cannot afford to pay dues of \$100 a year if members of labor unions pay more for less value received. The "Let George do it" attitude of a few members of the I.S.M.A. is too evident when they in turn do not belong to our parent organization, the A.M.A. Every physician in Indiana should belong to both organizations and his membership dues thereby show his appreciation for the work of the A.M.A. and its allied organizations, for if it were not for the A.M.A. there would be more Federal Medicine in operation than we have today.

The threat of socialized medicine has produced at least one admirable result, in that it has metamorphosed the apathy and disinterest of many of us, but not nearly enough of us, to one of interest and action. There is room for improvement. The district meetings which the I.S.M.A. holds annually are a sad commentary, either on the busy life of a physician or too much complacency engendered by that characteristic common to all of us called rugged individualism. It may be that few and better meetings is the answer, but when one suggests doing away with a solitary one, a few make sufficient noise to drown the voices of a host of timid souls for which more and more meetings really render inconvenience and hardship.

Watch the Social Planners!

In closing permit me to squirt some unadulterated lemon juice on the social planners who would like to pollinate the practice of medicine. Organized medicine must be "on guard" constantly because it is popular and remunerative for some folks to intimidate public opinion by writing articles and news reports which tend to belittle the sincerity of the majority, instead of emphasizing the faults of the minority, of the medical profession. Every organization, whether business or professional, has a few decayed apples in the occasional barrel, but in recent years the medical profession has made the headlines because social planners remember that Lenin once said that "socialized medicine is the keystone to the socialistic state." Some health and welfare workers and even physicians have had a tendency to flirt with the European system of medical care and the social philosophy of unlimited government aid. Government literature printed at our expense has directed welfare workers thus (quote) "A case worker should not label a man lazy if he does not want to work. He may be showing signs of mental or emotional illness." It further states that "welfare workers should be cautioned against asking children to help hard-up parents lest the natural impulse toward emancipation be unwholesomely checked." Similar psychological poppycock during the last 20 years has permeated the thinking of too many folks who direct our lay-health, public health, and philanthropic organizations all over America. As a veteran in the tuberculosis movement, I know allied groups too often offer to the medical profession an olive branch in one hand and a dagger in the other hand, either wittingly or unwittingly. They do not seem to be aware of the great struggle going on between the ideology of Americanism and the philosophy of Socialism and Communism. They do not know that it is much safer for America to correct the faults of its own system of medical care than to adopt a foreign system of medical care which is running interference for Communism and which will abolish our freedom to speak, our freedom to worship, and our freedom to live and work where we please. The fight which has been and is being conducted by the medical profession is not just our fight, but it should be the fight of every lay-health organization, because lay-health groups will be reduced to zero in the

advent of Federal Medicine. Foreign health programs, if adopted, will serve only as an investment to obtain political control of the Four Freedoms which we hope to preserve. And because people both in and out of these United States are intent upon using even the practice of medicine as a means to an end, we must keep on preparing America either to ward off or to fight another life and death struggle in behalf of the land of the free and the home of the brave, but no matter how brave, we cannot be free in a land fifth-columned by social planners who are jeopardizing our system of free enterprise. No one realizes the extent to which our patients' freedom has been threatened more than those who have been and are officials of our medical organizations.

In spite of untoward influences conscientious practitioners of the healing art have adhered to their obligations and as a result the science of medicine has progressed to a degree that from now on it will be difficult to find a cure for those pathological lesions which are still in a state of bafflement. Ultimately these conditions will be solved to the extent that the future may find the medical profession actually doing what the trite adage so well advises, that "An ounce of prevention is worth a pound of cure." It is a paradox when devotion to duty and scientific research gradually casts the physician out of his present day curative role into a preventive one. A physician puts forth his judgment, knowledge, and skill in a manner that makes most modern disease the vassal of his will. He possesses but one ideal, one heart, and one extended hand to all those who are ill, and never gives a patient up until the Grim Reaper the patient's heart doth still. "*Aegroto, dum anima est, spes est.*"

Therefore, as far as a physician's own conscience is concerned, he does more than his bit for humanity day in and day out, many times without compensation, but this does not answer those who think he should be more active, in a civic way, both monetarily and personally. Seldom does the public realize that "Life is short and art is long" and that the physician's recreation time, his home time, and his research time is limited. As members of organized medicine, we know this by experience, but we also know that our brother physicians are capable of decreasing their playtime and increasing their time for civic and medical obligations.

It is imperative that every physician become a "Don Juan" ready at all times "to draw the bow, to ride and speak the truth." Membership in the Indiana State Medical Association and the American Medical Association should be considered no longer just a dues-paying obligation of modern medicine. Translated, this means that you possess the intestinal fortitude to make sacrifices for the objectives of ethical medicine and that you are qualified to inform the public that before they decide on political medicine as a cure-all for everybody's health that they should weigh the maxim of Publius Syrus when he said, "There are some remedies worse than the disease." In conclusion, may I thank all who have participated in this year's program and may each follower of Hippocrates resolve

to tithe his time for organized medicine in 1954, For,

You'll get a kick out of working
For the I.S.M.A.
If you make no claim to giving,
Cheers, cuss words, tears, and song,
Time, money, brains, and brawn,
Just to help fellow doctors get along.

* * * * *

Why, you'll get a kick out of dying,
As a member of I.S.M.A.
If you know the Devil's vying,
With St. Peter to check upon,
Whether you died "Squeezing a Lemon"
Just to help fellow doctors get along.

WALTER L. PORTTEUS, M.D., FRANKLIN, NAMED PRESIDENT-ELECT OF I.S.M.A.

BY UNANIMOUS VOTE of the House of Delegates at the 104th annual convention of the Indiana State Medical Association, Walter L. Portteus, M.D., Franklin general practitioner, was selected as president-elect on October 21, 1953. He will assume office at the close of the 1954 Indianapolis convention.

A native of Indianapolis, Doctor Portteus received his medical degree from Indiana University School of Medicine in 1924. He established his practice in Cumberland, then moved to Franklin. He has successively filled the posts of president of the Johnson County Medical Society, councilor of the Seventh District, and member of the executive committee of the Indiana State Medical Association. Doctor Portteus has also served as secretary of the Blue Shield organization and a member of the board of directors of that group.

The president-elect has recently completed a special course in anesthesia to broaden the scope of his practice, is an inveterate reader of medical literature and has several constructive hobbies. Heading the list of his special interests is the promotion of the new Johnson County Memorial Hospital; and sharing equal importance are his woodworking activities (he has a small, well-equipped shop in his basement) and the pride he has in keeping a well-groomed lawn at his home.

Doctor Portteus is married to the former Harriet Sweet of Martinsville. The daughter of a doctor, she has a keen interest in medical organization, serving currently as recording secretary of the Woman's Auxiliary of the I.S.M.A.

Doctor and Mrs. Portteus have one daughter, Nancy, the wife of Jack Walters, president of the Student A.M.A. at Indiana University School of Medicine.

vide protection against wages lost because of sickness, hospital expense, surgical expense, and the costs of other medical care.

For many families any surgical operation with attendant wage loss and hospitalization represents a financial catastrophe, and the four customary forms of health insurance have collectively furnished such families with basic protection which they need and desire. That these forms meet a major public need is shown by the extremely rapid growth in the numbers protected by them.

However, a growing number of families—including those able to budget against the costs of an ordinary illness involving surgery—have come to feel a need for insurance against the costs of very serious illnesses leading to bills in excess of those covered by customary forms of health insurance. It is to meet this need that the new health catastrophe policies have been developed to supplement the basic health policy.

Policy Provisions and Premium Rates

Quite a range of catastrophe policies is already available, designed to fit the varying requirements of individuals, married couples, and families in differing circumstances.

Maximum benefit amounts. The maximum benefit amounts range, in policies so far available, between \$2,500 and \$10,000. The maximum may apply to any one illness, to any one family member, or to the total payable in any one policy year. Where the maximum applies to any one illness or individual, the total payable under the policy may of course be several times the specified maximum amount.

Deductible amounts. The new catastrophe policies generally promise to reimburse the insured individual or family on account of health expenses above an amount ranging from \$100 to \$500. These "deductible" amounts—which are similar to deductible amounts in automobile insurance—may be partly or wholly met by the benefits of a hospital, surgical, or other customary health insurance policy. The chief purposes of a deductible provision, besides preventing unnecessary duplication of policy benefits, are to simplify administration, to permit family budgeting against moderate expenses if desired, and to reduce premium costs to the policyholder.

Coinsurance percentage: The new policies ordinarily pay the insured person a percentage—usually 70 and 80 percent—of the health ex-

penses he incurs above the deductible amount and below the maximum. The insured person pays the remaining 20 or 30 percent, thus being a "coinsure" to that extent. The chief purpose of the coinsurance clause is to encourage the insured person to obtain at reasonable prices only such health services as appear to be needed. In consequence, benefit payments are more likely to be at reasonable level, with premium rates also remaining moderate.

The various individual and family policies offered by one company are presented in tabular form below. While other companies offer differing policies, the table should serve to furnish a general sense of the coverages available and the corresponding premium costs.

Illustrative Individual and Family Policy Provisions and Premium Rates¹

Insured	Maximum Benefit per Illness	Annual Premiums for Policies with Deductible Amount of		
		\$100	\$300	\$500
Individual Male	\$2,500	\$ 42	\$ 32	\$ 24
Individual Female	2,500	56	40	30
Husband and Wife	2,500	85	60	40
Family ²	2,500	115	75	50
Individual Male	5,000	60	46	35
Individual Female	5,000	84	62	46
Husband and Wife	5,000	130	95	70
Family ²	5,000	175	125	90

¹ The company offering these policies pays all hospital room and board charges up to a daily limit of \$10 under the \$2,500 or \$15 under the \$5,000 policies, and pays 75% of all surgical and other covered health expenses in excess of the deductible amount.

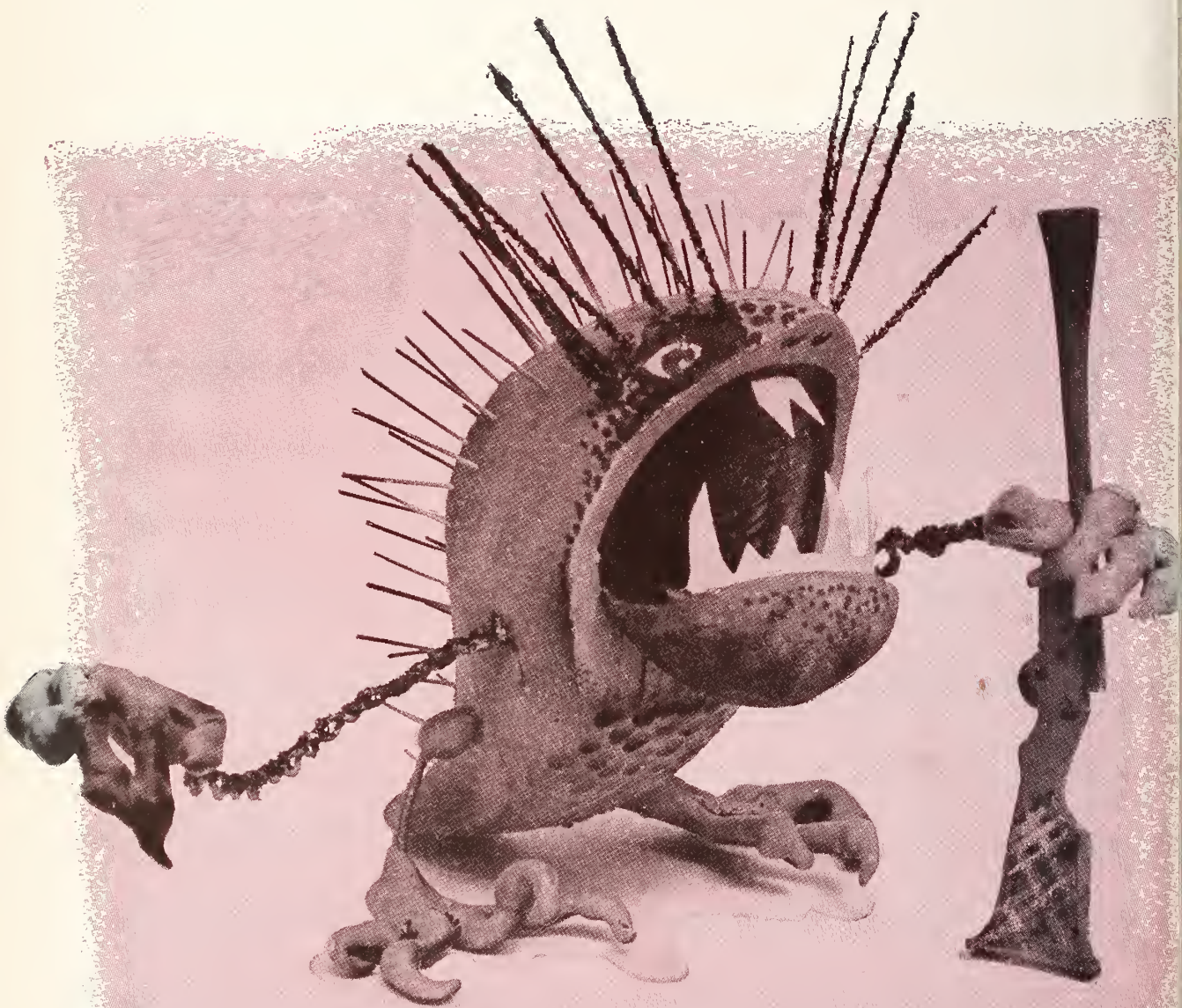
² Husband, wife, and one or more children.

The new health catastrophe policies are still in an experimental stage, and the insurance companies are anxious for them to prove successful. But cooperation by doctors, hospitals and the public generally is necessary if the new form of health insurance is to realize its promise. Doctors and hospitals can cooperate with the companies by avoiding any increase in their charges by reason of the apparent increase in the insured person's ability to pay. Similarly, those purchasing the new policies can help to keep premium rates moderate by not incurring needless health expenses.

* Doctor Dickson presented this paper as part of a panel discussion on "Health Insurance As It Relates to the General Practitioner" at the 1952 I.S.M.A. convention in Indianapolis.

W

hen patients are sensitive to antibiotics



48 DOCTORS COMPLETE 50 YEARS OF SERVICE TO FELLOW HOOSIERS

Unusually good attendance marked the annual reception for members of the Fifty Year club of the Indiana State Medical Association. The affair was held in the Hunt room of the French Lick Springs Hotel, October 21.

Dr. H. G. Weiss, Evansville, served as chairman of the committee in charge of arrangements.

Doctors, who had just received their 50 year pins and certificates, and members of their families heard Bish Thompson, Evansville Press columnist, give an interesting talk highlighted with homespun philosophy.

Dr. Paul D. Crimm, I.S.M.A. president, greeted the new and old members of the club and an informal hour followed during which punch was served.

Doctors who received the framed certificates and Fifty Year Club pins were: Leonard A. Ensminger, Indianapolis; Murray N. Hadley, Indianapolis; Kenneth I. Jeffries, Indianapolis; Edgar F. Kiser, Indianapolis; Harry S. Mackey, Indianapolis; Harrison S. Thurston, Indianapolis; Harry J. Weil, Indianapolis; Henry O. Bruggeman, Fort Wayne; Homer E. Glock, Fort Wayne; Albert Stoler, Fort Wayne; Charles W. Atkinson, Boswell; James E. McCabe, Otterbein; John C. Bradfield, Logansport; Harry M. Shultz, Logansport; James F. Treon, Aurora; Emil F. Steinkamp, Huntingburg; Claude F. Fleming, Elkhart; Clarence E. Briscoe, New Albany; Arthur E. Stinson, Rochester; Amos H. Rhodes, Princeton*; M. Luther Hamilton, Newberry; George C. Porter, Linton; George E. Lowe, Noblesville; Alonzo C. Newby, Sheridan; William E. Amy, Corydon; Dennis W. Matthews, North Vernon; C. L. Boyd, Vincennes; David H. Richards, Vincennes; H. L. Miller, West Baden Springs; S. C. Darroch, Cayuga; Edgar H. Powell, Valparaiso; Clyde C. Gray, Cloverdale; William S. Coleman, Carthage; Charles S. Bosenbury, Coral Gables, Florida, (formerly of South Bend); P. G. Skillern, South Bend; S. B. Coulson, Waldron; F. S. Crockett, Lafayette; Elmer B. Moser, Windfall; Burtis L. Cody, Evansville; William S. Ehrich, Evansville; Louis E. Fritsch, Evansville; Daniel G. Tweedall, Evansville; Charles N. Combs, Terre Haute; Daniel B. Miller, Terre Haute; Etta Selsam, Terre Haute; Harvey Hadley, Richmond; Paul S. Johnson, Richmond; and Frederick W. Krueger, Richmond.

* Doctor Rhodes' death occurred on October 15, less than a week before he had planned to attend the Fifty Year Club reception at French Lick. A full obituary will be carried in the December JOURNAL.

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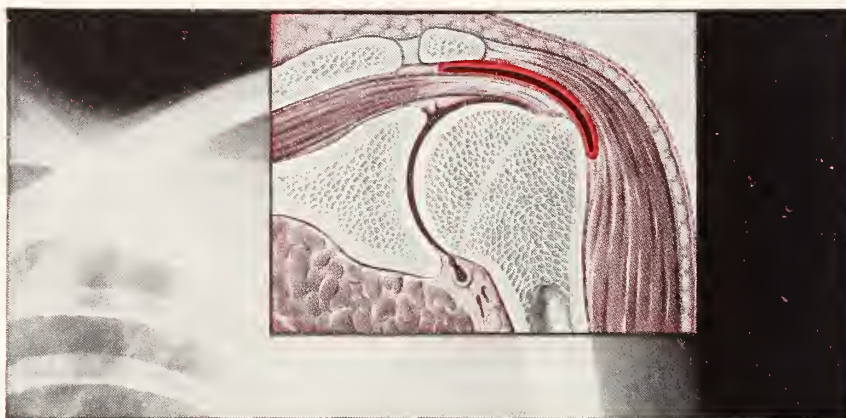
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Deaths

Marshall B. Catlett, M.D., 65, Fort Wayne surgeon since 1914, died in Methodist hospital in that city October 7. He had been admitted to the hospital September 22 and had been in ill health for several months. Doctor Catlett received his medical degree from Indiana University School of Medicine in 1913. He had also studied abroad, receiving a degree from the University of Montpellier, France.

Doctor Catlett served as a medical officer with the rank of captain during World War I. He had been active in medical organization work and civic affairs. He resigned as a member of the Fort Wayne City Board of Health in June after 16 years service; he also resigned as councilor of the Twelfth District, Indiana State Medical Association. Previously he had served in 1928-29 as president of the Fort Wayne Medical Society and as a member of Fort Wayne City Planning commission. He was active in church, fraternal and lodge affairs.

Ray G. Ikins, M.D., 57, died September 28 in the family home in Lafayette following a serious illness of one month. A native of Illinois, Doctor Ikins was graduated from Indiana University School of Medicine in 1919 and served his internship at the I.U. Medical Center. He began the practice of medicine in Lafayette in 1921, joining the Arnett Clinic. He remained there until 1934 and had since practiced in association with Dr. Thomas Graham and Dr. George Herrold.

Doctor Ikins was a veteran of both World Wars, attaining the rank of major during World War II. He was a fellow of the American College of Surgeons, a member of Tippecanoe County Medical Society, the Indiana State and American Medical Associations.

Frank Rodenbeck, M.D., 71, Arcadia physician for almost 50 years, died September 17 in his home after becoming suddenly ill in his office earlier in the day. He had been in failing

health for several years but had maintained his practice. Born near the site of his office, Doctor Rodenbeck was graduated from the Medical College of Indiana in 1904 and had practiced continuously since in Arcadia. He was a member of Hamilton County Medical Society and the Indiana State Medical Association.

Jap F. Swayne, M.D., Indianapolis physician for the last 15 years, died October 7 following surgery in Passavant Hospital, Chicago, after an illness of one year. A native of Vermillion county, Doctor Swayne practiced at Clinton for 20 years following his graduation from Indiana University School of Medicine in 1913. Doctor Swayne, who was a World War I veteran, was 66. He was a member of Indianapolis Medical Society, Indiana State and American Medical Associations.

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News Notes

Doctor Completes 35 Years Service with Lilly's



Ben F. Hatfield, M.D., who joined Eli Lilly and Company in 1917 as the first physician in the industrial medicine and safety department, has retired from that firm after 35 years service. He served as manager of the department until 1948 and since has been a company consultant.

Doctor Hatfield is in private practice in the Chamber of Commerce building, Indianapolis.

Doctor Hamilton is a 1941 graduate of Indiana University School of Medicine.

Doctors of the Johnson County Medical Society in cooperation with Johnson County Memorial Hospital established a Doctors' Exchange September 24 in an effort to provide better medical service to residents of that area. The service will be operated on a 24-hour basis from the hospital and through it patients should be able to contact their family doctor at any time. In case of an emergency on Sundays, Wednesdays and holidays, a roster of physicians is also maintained which provides services of some doctor at all times.

Dr. Antha A. Hamilton, who has been in practice in Shelburn for 12 years, has opened an office in Vevay in the National Bank building.

A Connersville native, Dr. Charles Matheus, has returned there, and will enter the general

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\$50 weekly indemnity, accident and sickness		\$100 weekly indemnity, accident and sickness	

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Laboratory Fees in Hospital.....	5.00	10.00	15.00	20.00
Operating Room in Hospital.....	10.00	20.00	30.00	40.00
Anesthetic in Hospital.....	10.00	20.00	30.00	40.00
X-Ray in Hospital.....	10.00	20.00	30.00	40.00
Medicines in Hospital.....	10.00	20.00	30.00	40.00
Ambulance to or from Hospital.....	10.00	20.00	30.00	40.00

COSTS (Quarterly)

Adult	2.50	5.00	7.50	10.00
Child to age 19.....	1.50	3.00	4.50	6.00
Child over age 19.....	2.50	5.00	7.50	10.00

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practice of medicine. He was graduated from I. U. School of Medicine in 1952 and served a one year internship at San Bernardino County Hospital, San Bernardino, California.

Dr. Joseph Steinem opened an office for the general practice of medicine in Connersville, September 21. A graduate of Indiana University School of Medicine in 1948, Doctor Steinem practiced medicine in Cincinnati, his native city, for two and a half years before serving as a lieutenant in the Navy Medical Corps. He was separated from service August 30. His office has been established at 523½ Central in the McFarlan Building and his residence at 2300 Grand. Mrs. Steinem is a registered nurse, graduate of I. U. in 1948.

Dr. James Garrison has resumed the practice of medicine in Cumberland after two years service in the army overseas. Dr. Joseph Miller, who practiced in Cumberland during Doctor Garrison's absence, has returned to Indianapolis.

Dr. Joseph George, a graduate of Louisiana State University Medical School and a veteran, has opened an office for the general practice of medicine in Edinburgh. He will be in the new Donovan Runshe building and will have only evening office hours for the present. He has not been in practice previously. Recently he was in the office of Dr. Don Manuel while the later was on vacation.

Midwest ACP Meeting in Milwaukee November 21

The Midwest Regional meeting of the American College of Physicians has been scheduled for the Hotel Schroeder, Milwaukee, on November 21.

Illinois, Indiana, Iowa, Minnesota and Wisconsin's 875 College members comprise the group that will hear a scientific program of 22 papers (15 minutes each) and attend a Clinico-Pathological Conference. Luncheon, a banquet and evening entertainment as well as special entertainment for the women are also on the day's program. There is no registration fee for members or non-members, according to Dr. Joseph W. Rastetter, chairman of arrangements.

First Evansville Forum Draws 800; Topics Selected

The first Sunday night forum, sponsored jointly by the Vanderburgh County Medical Society and the Evansville Press attracted 800 persons to Bosse High School auditorium to hear the initial panel on "Cancer". Local doctors participated.

The second forum on "Heart Disease and Blood Pressure" was scheduled for October 11. The remainder of the series on topics chosen by popular vote will include: "How to Grow Old and Like It", October 18; "Arthritis and Rheumatism", October 25; "Sinus Disease and Tonsils", November 1; "The Role of Psychiatry in the Community", November 8; "Overweight and Health", November 29; and "Ulcers and Indigestion", December 6.

Dr. R. L. Rouen, an eye specialist, has opened an office for private practice in the Monger Building, Elkhart. He was released recently from the Navy medical corps after 10 years service. Doctor and Mrs. Rouen and their four children reside at 816 Christiana Court, Elkhart.

Dr. C. William Goebel, who recently completed his second tour of active duty with the U. S. Air Force, has opened offices at 2318 South Fairfield Avenue, Fort Wayne, where he will limit his practice to pediatrics. He was in practice in Fort Wayne before entering service.

Dr. Dennis Nicholas, who recently completed two years of internship and residency training at General Hospital, Indianapolis, has taken over the medical practice of Dr. Earl J. O'Brien at 2425 East 38th Street, Indianapolis. Doctor O'Brien was recalled recently to military service. Doctor Nicholas is a graduate of Indiana University School of Medicine.

Dr. Joseph H. Geyer, who served in the Army medical corps from 1943 to 1946 and was recalled in 1951, was recently separated from the Army after service in Korea. He has established offices in Ashley. He is a graduate of Ohio State University College of Medicine, later serving as assistant professor of medicine there. Doctor and Mrs. Geyer are now living in Ashley.

Doctors Participate in Auxiliary's Health Workshop

"Diseases of the Eye" was the topic discussed by Dr. Marvin Cuthbert, Indianapolis, at the Health Workshop held September 30 in the Community building at Russiaville under the direction of the Woman's Auxiliary to the I.S.M.A.

Following Doctor Cuthbert's paper, a panel on "Cancer" was moderated by Mrs. W. B. Matthew, Auxiliary president. Participants were Dr. Lall G. Montgomery, Muncie, vice-president of the Indiana Cancer Society and chairman of its research committee, and Mrs. James Cloettingh, South Bend, director of the National Cancer Society.

Dr. D. W. Paris, Kokomo, presented a paper on "Diseases of the Heart" immediately following a luncheon and at 1:30 a "Health Problems" panel, with W. R. Cox, of Kokomo's WIOU, as moderator was presented. Speakers included Francis Marion, Kokomo fire chief; Dr. Garvey Bowers, Kokomo; George Nuffer, health consultant, Purdue Extension; Dr. E. R. Clarke, Kokomo; and Mrs. Charles Sewell, Otterbein, who summarized the panel talks.

Dr. P. L. Sthair, a native of Goshen and 1949 graduate of Indiana University School of Medicine, is opening offices at 506-08 in the Glass Block, Marion, where he will specialize in internal medicine. Doctor Sthair interned at Indianapolis General Hospital and recently completed a three year residency in internal medicine there.

Arne E. Stensby has joined the New York City offices of the Borden Company's Prescription Products Division as a director of professional relations. A graduate of the University of Wisconsin School of Pharmacy, Mr. Stensby joined Eli Lilly and Company in 1935 in Milwaukee and in 1944 became manager of the company's product promotion and sales training department at Indianapolis. Three years later he was named manager of its professional relations department where he remained until 1952 when he joined the Merrell company of Cincinnati.

Dr. Robert J. Steckler, Evansville native, has opened offices in a new brick and stone building at 1400 Cass Avenue at Lodge in that city where he will practice general medicine and surgery. Doctor Steckler is a 1949 graduate of the University of Maryland School of Medicine and College of Physicians and Surgeons and served both internship and residency at San Joaquin Hospital in California. He spent a year in Korea. Since April he has been assisting other Evansville physicians until his new offices were completed.

Three AHA Programs For 1954 Scheduled

The Annual Meeting of the American Heart Association will be held in Chicago from April 1 through April 4. The assembly panels and general assembly will be held on April 1 and 2 followed by the two-day program of the newly formed Section on Clinical Cardiology. This meeting immediately precedes the Annual Sessions of the American College of Physicians.

Members of the American Heart Association who wish to present papers are asked to send a 250-300 word abstract of their proposed paper to Dr. Charles Marple, Medical Director, American Heart Association, Inc., 44 East 23rd Street, New York 10, New York. All papers should be on subjects of distinct clinical interest and must be submitted by January 1, 1954.

The Scientific Sessions of the AHA will be held in Washington, D. C., September 16 through 19, following the International Congress of Cardiology which will be held September 12 through 15, also in Washington.

The 20th Annual Meeting of the American College of Chest Physicians will be held in San Francisco, June 17-20, 1954. Physicians who wish to present papers on any phase in the diagnosis and treatment of heart and lung disease should send a 100 word abstract, not later than January 1, 1954, to Dr. Edgar Mayer, Chairman of the Committee on Scientific Program, 850 Fifth Avenue, New York 21, New York.

553 Polio Cases Reported In State During 1953

Figures compiled in the October 10 bulletin of the Indiana State Board of Health, Communicable Disease Control division, reveal a total of 553 cases reported and 23 deaths. Of that total, 27 were of the abortive type, 197 non-paralytic, 270 paralytic and 59 unspecified.

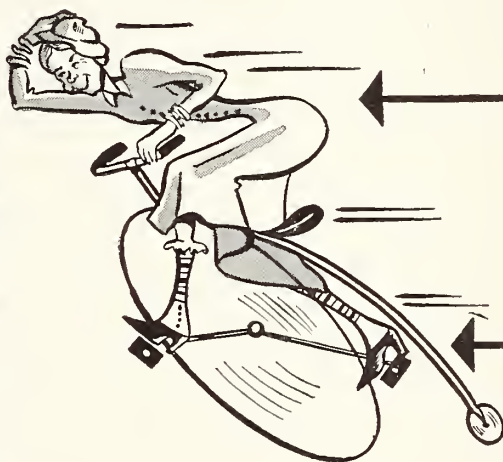
The 1953 totals compared with totals for the last five years show that the number of cases exceeded the 1953 figures twice during that period. There were more deaths in three out of the five years.

Dr. James O. Coursey, graduate of the University of Illinois College of Medicine, is now associated with Dr. M. Hunter Smith in the general practice of medicine in Goodland. Doctor Smith was to report for duty at the U. S. Naval Hospital, Oakland, California, October 15. Doctor Coursey served as a flight surgeon in the USAF after completing his internship at West Suburban hospital, Oak Park, Illinois. The two doctors plan to continue their association in Goodland following Doctor Smith's return.

Two classmates at Indiana University School of Medicine, **Dr. Philip E. Prather** and **Dr. Stanley M. Mendelson**, have formed a partnership in Kokomo with offices at 117 West Markland Avenue. Both are in the general practice of medicine. Both are veterans of World War II. Doctor Prather is a native of Indianapolis. Doctor Mendelson was born in New York City and lived in upper New York State for 18 years. He was graduated from I. U. in 1952.

Dr. Jonathan G. Yoder, who has been in charge of a hospital in India for 14 years, has returned to his former home in Goshen where he will practice medicine at 314 East Lincoln Avenue. Doctor Yoder went to India in 1937 as a medical missionary. He returned to Goshen on an 18 months furlough in 1945, practicing during that time.

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Cash Award Offered for Essay on Infertility

The American Society for the Study of Sterility announces the opening of the 1954 contest for the most outstanding contribution to the subject of infertility and sterility. The winner will receive a cash award of one thousand dollars, and the essay will appear on the program of the 1954 meeting of the Society. Essays submitted in this competition must be received not later than March 1, 1954. For full particulars concerning requirements of this competition, address The American Society for the Study of Sterility, c/o Dr. Herbert H. Thomas, Secretary, 920 South 19th Street, Birmingham, Alabama.

The author should append on a separate sheet of paper a short biographical sketch of himself and include a photograph to be used in the necessary publicity should he be the winner of the award.

\$5,000 Schering Award Goes to St. Louis Doctor

Dr. James E. Ashmore, St. Louis, has been named recipient of the Schering Fellowship in Endocrinology for 1953, according to an announcement by the Awards Committee of the Endocrine Society. The fellowship will enable Doctor Ashmore to broaden his studies of the physiological aspects of endocrine research. He will study at Harvard University.

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A. M. A. Washington Office News

U. S. Chamber Charts Growth of Commercial Health Insurance. A U. S. Chamber of Commerce survey of commercial insurance companies and insurance societies shows these organizations are making steady progress in selling individual hospital, medical, and surgical insurance policies. Not included in the survey are Blue Cross, Blue Shield, mutual benefit associations, salary-continuance plans, union benefit plans, and other methods of voluntary group coverage. Thus the findings do not show the total extent of coverage. The study covered 1952, and is based on information or estimates from 233 firms or societies issuing individual policies. By type of insurance, the survey showed:

Medical Expense (excluding surgery): The highest percentage increase, 21%, from 4.2 millions covered in 1951 to 5.1 millions in 1952. *Surgical Insurance*: The largest numerical increase, with 2.8 millions more covered, from 16.4 million to 19.2 million, a percentage increase of 17%. *Hospitalization*: Most popular of all, it increased 10.1%, from a coverage of 21.6 million in 1951 to 22.3 million in 1952, or a numerical increase of 700,000. *Disability Insurance* (payments to workers kept from the job by sickness or accident): Only a slight increase, from 12.5 millions covered to 12.6 millions.

This was the first time the Chamber surveyed the new *catastrophic* insurance so it was not possible to establish a rate of growth. At the end of 1952 more than 156,000 persons were covered by catastrophic insurance, which complements the usual hospitalization, surgical and medical policies by paying 70 or 80 per cent of the additional cost up to a usual maximum of \$10,000. (A complete survey of the growth of all health insurance has just been released by the Health Insurance Council.)

The report was printed in *American Economic Security*, Vol. 10, No. 5. Reprints are available at no cost at the U. S. Chamber of Commerce, Washington, D. C.

Navy Sets Up New Policy on Release of Regular Medical Officers. The Navy announced a new policy aimed at making a career in Navy medicine more attractive to young doctors. It would work this way: resignations will be accepted from medical and dental corps officers who are initially appointed as lieutenants (j. g.) or lieutenants on or after August 7, 1953 and who thereafter serve in the regular component of their corps on active duty for four years. The Navy's chief of personnel comments: "This policy will free young medical and dental corps officers from the feeling that they are captives." In computing four years service, any time spent in internship, residency or other postgraduate training or any period of obligated service acquired through such training won't be counted.

Policy on resignations of physicians and dentists who entered the regular naval service before August 7, 1953 remains unchanged for the time being. Resignations are considered on an individual basis, depending on data listed in the resignation request; hardship is one of the major considerations. Bureau of Naval Personnel currently is studying new resignation criteria for this group, with the possibility of establishing a more definite policy.

Lawmakers Rate 4 Medical Bills Important Next Session. In the opinion of a representative group of Senators and Representatives, four issues of significance to the medical profes-

sion will be among the more important questions to come before the next session of the 83rd Congress. The lawmakers' sentiment was sounded out by Congressional Quarterly, a factual news service devoted to reporting and analyzing Capitol Hill trends. The poll was participated in by 186 Representatives and 39 Senators, divided about evenly between the two parties. Forty subjects were submitted, with the request that they be graded in order of importance. The four medical issues:

Social Security. This landed in sixth place in the poll. The question is this: Shall an additional 10.5 million persons, including physicians, be brought under social security coverage? President Eisenhower in the closing days of the last session asked for this legislation, but there was no time for action. It will be pressed by the administration next session.

Tax Legislation. This was rated ninth in importance. While the House Ways and Means Committee is working on a complete revamping of tax laws, the *Jenkins-Keogh* plan is of paramount importance to physicians. It would allow physicians and other self-employed persons to defer income tax payments on a portion of their income which would be put into restricted annuity programs. Corporation employees now have this privilege. This plan has the strong support of AMA.

Aid to Schools, Hospitals. This placed thirteenth. The question was broad, but presumably it would include aid to hospitals and clinics under a national health plan as well as support for the Hill-Burton hospital construction program.

Veterans' Services. This is regarded as fifteenth in importance. Again the wording was broad, but included would be the question of whether Congress should expand or restrict care of non-service connected cases. AMA is proposing that care be restricted to (a) service-connected cases, and (b) certain long-term non-service cases where the veteran himself cannot pay. All other non-service cases would be the responsibility of the individual himself or the community.

No Doctor Draft Calls Expected for 12 Months, Committee Advises. National Advisory Committee to Selective Service believes there will be no further calls for physicians registered under the doctor draft for about a year. The committee, in a report dated September 2 and sent to state Selective Service directors, chairmen of state advisory committees, deans of medical schools and others, states: "It is not expected that there will be additional calls for physicians placed against the Selective Service System by the President for the next 12 months." It adds:

"As a result of Call No. 16 in August (for 542 physicians) and the increased number of volunteers, there have been commissioned a sufficient number of physicians to meet the needs of the armed forces for the immediate future. Those who have been commissioned from either the voluntary list or the Selective Service call will be brought to active duty from time to time until this reservoir is exhausted." The committee says there may be some calls for dentists after several months.



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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

September 13, 1953

Roll call showed the following present: W. L. Porteus, M.D., chairman; James W. Denny, M.D.; Paul D. Crimm, M.D.; E. R. Clarke, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump, attorney; James A. Waggener, executive secretary, and Robert J. Amick, field secretary.

Membership Report

Number of members September 11, 1953...3,765*
 Number of members September 11, 1952...3,672
 Gain over last year.....87
 Number of members December 31, 1952...3,783

* Includes 143 in military service (gratis)

109 \$10 members (residents and interns)

249 senior members

75 members, dues remitted by Council

Number who have paid AMA dues:

1951....2,997; 1952....3,569; 1953....3,578*

* 420 members who were permanently exempted in 1952 are included in above figure.

Headquarters Office

On motion of Drs. Denny and Clarke, the secretary was given permission to buy new pockets for the membership files.

1953 Annual Convention, French Lick, October 19, 20 and 21, 1953

The scientific and entertainment programs were approved as presented, the only change being that the Tuesday night entertainment is to be held in the main dining room rather than in the convention hall as proposed by the Entertainment Committee.

Fifty-Year Club reception. On motion of Drs. Myers and Denny, \$150.00 was budgeted for expense of the Fifty-Year Club reception.

Speakers' table and guest table lists were approved by consent.

Organization Matters

Physician of the Year Award. A report was given on the meeting held by telephone by members of the Executive Committee and members of the Council, and the result of the vote taken. Upon motion of Drs. Crimm and Denny the award is to be given on the basis of the new rules recommended

by the Executive Committee, and the wording on the plaque is to be retained as submitted.

Letter read relative to a loan being available from the association to medical students, and upon motion of Drs. Denny and Clarke the president was instructed to appoint a committee of three members to study the establishment of a revolving loan fund and to bring a report back to the Executive Committee.

Medical Defense

The secretary suggested the publication of a booklet on medical defense which would serve to inform the members of the profession regarding statements made to patients which might lead to suits and to contain release forms for the doctors to have signed for the various procedures. After discussion the secretary was requested to work this out with the attorney and bring it back to the Executive Committee.

Future Meetings

The A.M.A. annual meeting in San Francisco, June, 1954, was discussed and the executive secretary was instructed to arrange a special tour for Indiana members and bring the information in to the next Executive Committee meeting.

Information received from Cincinnati Academy of Medicine regarding a Civil Defense meeting in Cincinnati, November 14 and 15, 1953, was presented, and upon consent the committee agreed that Indiana need not be represented at this meeting.

Invitation from the Indiana State Chamber of Commerce that the Association be represented at the Board of Directors' meeting of the Indiana State Chamber of Commerce, to be held at Gary, October 2, 3 and 4, 1953, was read and by consent it was agreed to ask Dr. Howard to represent the Association.

New Business

Interim session. The secretary reported on the returns received from the county medical societies on the survey on the question of discontinuance of the interim session. The secretary was instructed to tabulate the returns showing total members represented and the weight of delegate strength in the counties for and against.

Resolutions which had been received by the state office for presentation to the House of Delegates were called to the attention of the committee.

Resignation of Dr. Minor Miller as a member of the Board of Appeals was read and Dr. Crimm appointed Dr. C. C. Herzer of Evansville to fill Dr. Miller's unexpired term.

Letter read from Michigan State Medical Society in which they solicited the opinion of the Indiana

State Medical Association relative to cooperative effort in the production of films to combat some of the existing fallacies that exist in the public's mind regarding the practice of medicine. The committee recommended that Indiana reply to Michigan to the effect that they felt this should be worked out through the American Medical Association rather than through any one society.

There being no further business, the committee adjourned to meet again at noon, Sunday, October 18, 1953, in the Blue Room, French Lick Springs Hotel, French Lick, Indiana.

MINUTES OF MEETING OF EXECUTIVE COMMITTEE OF THE INDIANA STATE MEDICAL ASSOCIATION WITH THE WOMAN'S AUXILIARY TO THE INDIANA STATE MEDICAL ASSOCIATION, HELD AT THE COLUMBIA CLUB, INDIANAPOLIS

September 13, 1953

Present: Mesdames W. Burleigh Matthew, president; Harry C. Harvey, president-elect; William Tindall, 1st vice-president; John Sullivan, treasurer; W. L. Portteus, recording secretary; Roy V. Myers, chairman of Council; Morris Wertenberger, legislative chairman, and Frank Green, editor, Hoosier Doctor's Wife.

The chairman of the Executive Committee welcomed the members of the Woman's Auxiliary to the Indiana State Medical Association and called on Mrs. Matthew, president of the Auxiliary, to present any matters the Auxiliary had to come before the Executive Committee.

Mrs. Matthew expressed the appreciation of the Auxiliary for the opportunity afforded them to discuss their program with the committee and outlined the following program, as proposed by the Auxiliary and presented to the committee for their consideration and approval:

1. The Auxiliary currently has 2,300 members.
2. 6,300 is the membership at the National level.
3. Sixty-five auxiliaries have been organized in Indiana, representing all counties with the exception of five unorganized counties, consisting of Wabash, Clinton, Scott, Pike and Posey.
4. A large percentage of the Auxiliary members are wives of men who are not active in the Association programs and therefore constitute a very important source for spreading information regarding the Association.
5. The by-laws of the Auxiliary state one of the primary objectives of the Auxiliary is to assist the Medical Society in every way possible.
6. The Auxiliary is a subscription selling agency for the official health publication of the AMA, TODAY'S HEALTH. Mrs. Matthew pointed out that some physicians seemed to object to having this publication in their waiting rooms, and told of the support given the Auxiliary in Vanderburgh County by the Medical Society in making it possible to place the magazine in all barber and beauty shops in Evansville. She stated the Auxiliary was hopeful the Association would encourage more societies to assist in making a better distribution of the publication in their communities.
7. The question of handling of legislative matters by the Auxiliary was discussed, Mrs. Matthew stating it was the hope of the Auxiliary that a closer liaison could be maintained with the Association and that pertinent information could be channeled to the Auxiliary as well as to the members of the Association.
8. The work of the Auxiliary in the field of Rural and School Health was discussed and it was pointed out that inasmuch as the program of the Association was being changed the Auxiliary would await further instructions from the proper committees of the Association before doing anything further in these fields.
9. In matters of Public Relations, the Auxiliary is carrying on the following activities:
 - a. Nurse recruitment.
 - b. Nursing scholarship programs.
 - c. Organization of "Jugs" at the county level. This is an organization of Junior High School girls who are willing to assist in various jobs around the local hospital during their spare time.
 - d. Encouraging local auxiliaries to encourage their members to take an active part in all local community civic programs and achievement programs.
10. The budget of the Auxiliary was presented, Mrs. Matthew stating it was their hope to be able to operate during the coming year within their own income limits and still have a balance of some \$183.00 at the end of their current fiscal year.
11. Medical Education Foundation and the drive for funds is of great interest to the Auxiliary and during the past year the Auxiliaries of Indiana have contributed one thousand six hundred and sixty-five dollars to this fund. Mrs. Matthew stated they had begun a campaign to encourage their members to make memorial gifts to the fund rather than send flowers to their deceased members.

12. Mrs. Matthew stated the Auxiliary had come to the Association for information on what the Association wanted the Auxiliary to do.

A discussion of the various points of the program as outlined was had and the following was the action of the committee:

General approval was voiced on the program as presented and it was the feeling of the committee that the Auxiliary should be commended for their outstanding work and sincere interest shown in the affairs of medicine.

The committee agreed that county societies should be encouraged to assist in obtaining wider distribution of TODAY'S HEALTH, that not only should physicians have copies in their waiting rooms, but also should consider the possibility of placing copies in public places and the public schools.

That interest in the Medical Education Foundation should be maintained and that the Association might well follow the example of the Auxiliary in recommending to its members the making of a memorial gift to the Fund in lieu of sending flowers in case of death.

Upon motion of Drs. Crimm and Denny the committee voted to publish sufficient copies of the chiropractic manual for distribution to all county auxiliaries, and to send them copies of all other material on this subject that is available.

SEVENTH COUNCILOR DISTRICT

Lester D. Bibler, M.D., Indianapolis, was named Seventh District Councilor to the Indiana State Medical Association, at the fall meeting of the district held in Indianapolis Country Club, October 14.

Doctor Bibler succeeds Dr. Roy A. Geider, also of Indianapolis, who would not accept renomination. Doctor Bibler's term will begin January 1, 1954 and is for three years.

Dr. Maurice G. Murphy, Morgantown, was named president-elect for 1955, and Dr. T. V. Petranoff, Indianapolis, was reelected secretary-treasurer. Dr. Elmer L. Koch, Danville, will succeed Dr. Ralph V. Everly as president.

The 1954 spring meeting will be held in May in Indianapolis.

Eighty-nine members, wives and guests attended the dinner. Roger D. Branigin, Lafayette attorney, was the speaker.

ELEVENTH COUNCILOR DISTRICT

Dr. Cecil G. McEachern, Fort Wayne, and Dr. Leonard Condon, Chicago, were the scientific speakers at the Ninety-Second Semi-Annual Meeting of the Eleventh District Medical Association



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T. J. Smith, M.D., Associate

held in the Moose home in Huntington, September 16. Doctor McEachern spoke on "Differential Diagnosis of Acute Abdominal Pain" and Doctor Condon's paper was on "Medical Emergencies." A general discussion followed.

Dr. George Wagoner, Delphi, presided at the business session which preceded the scientific program. Marion was selected as the next district meeting place and the date set for May 19, 1954.

Dr. Max R. Adams, Flora, was named alternate councilor.

Following the 6:00 o'clock dinner, Dr. W. A. Clunje, Huntington, introduced the speaker for the evening, Mr. J. C. Brenn, head of Huntington Laboratories, who spoke on "Socialism and Communism in Europe".

During the session a resolution was passed commending Dr. George R. Daniels, Marion, who will attend his fifty-third convention of the Indiana State Medical Association this year. Doctor Daniels is a past president of the state association.

LOCAL SOCIETY REPORTS

Wells County Society Presents Scientific Program

Nationally known medical specialists, among them a Canadian physician, presented a program on varied subjects at the seventh annual Fall Clinical Conference of the Wells County Medical Society in the Bluffton Country Club on October 7.

The annual affair was attended by 97 doctors from counties in northeastern Indiana.

Dr. Andre Robert, assistant professor, Institute of Experimental Medicine and Surgery, University of Montreal, concluded the afternoon and evening conference with a paper on "Recent Research on Stress and on Inflammation".

Speaking at the dinner on "Your State Association", Dr. Paul D. Crimm, Evansville, president of the Indiana State Medical Association, emphasized the importance of individual physicians playing more active roles in the affairs of their local society and their state association.

Indiana University's Dr. Jacob K. Berman, associate professor of surgery, spoke on "Surgical Considerations in the Treatment of Mitral Stenosis."

Other doctors who participated were Dr. James H. DeWeerd, section on urology, Mayo Clinic, Rochester, Minnesota; Dr. Warren W. Furey, assistant professor of radiology, Loyola

University, Chicago; Dr. H. M. Pollard, professor of internal medicine, University of Michigan, Ann Arbor; and Dr. S. William Simon, Brown General Hospital, Dayton.

Dr. Maurice Glock, Fort Wayne, new District Councilor, and Dr. David D. Oak, LaCrosse, were introduced and responded with short talks.

One hundred and twenty-five members of **Fort Wayne (Allen County) Medical Society** were guests of Irene Byron Sanatorium at a dinner meeting September 2 in the hospital. Dr. W. R. Clark, program chairman, introduced Dr. O. T. Kidder, administrator at the sanatorium who in turn presented the following speakers: Dr. Holland Thompson, who spoke on "Medical Management and Diagnosis"; Drs. J. Vincent and Clarence Sherwood, who discussed "Surgery and Anesthesia" and Dr. Charles E. Gill, "Modern Medical Treatment in Tuberculosis."

At the October 6 meeting of the society in the Chamber of Commerce, Charles P. Bailey, M.D., professor and head of the Department of Thoracic Surgery, Hahnemann Medical College and Hospital, Philadelphia, spoke on "Recent Contributions to Cardiovascular Surgery." The dinner meeting and scientific program were attended by 100 members.

Programs and activities for the coming year were discussed at the business meeting held September 1 by the **Boone County Medical Society**. Discussion followed a dinner at 6:30 o'clock in Witham Memorial Hospital, Lebanon. Eleven members attended.

J. Harold Mertz, principal of Logansport High School, was the after dinner speaker at the first fall meeting of the **Cass County Medical Society**, held in the Logansport Country Club. He discussed "The Relation of the School to the Doctor". A business meeting followed the dinner.

Members of **Elkhart County Medical Society** attended a symposium on heart disease October 1 in the Hotel Elkhart. The program was the second annual "Road Show" sponsored

by the Indiana Academy of General Practice and the Indiana Heart Foundation. Speakers were Dr. Roy W. Scott, professor of clinical medicine at Western Reserve University, Cleveland, who is former president of American Heart Association, and Dr. A. A. Luisada, director of the division of cardiology at the University of Chicago.

Dr. Max D. Bartley, Indianapolis, was the guest speaker at the first fall meeting of the **Hamilton County Medical Society** held in Riverview hospital, Noblesville. He discussed eye diseases and roundtable discussion followed. Dr. Haldon C. Kraft, president, was in charge of the meeting.

The **Jefferson-Switzerland County Medical Society** met September 8 in the quarters of Dr. O. B. McAtee, superintendent of Cragmont State Hospital, Madison, for a buffet supper and symposium on bisexuality. Thirty members and guests attended. The following papers were presented: "Review, Anatomy and Embryology of the Urogenital System", L. C. McCloud, student interne; "Review, Case of Christine Jorgenson", Stephen Burkhart, student interne; "Review, Admissions of Sexual Deviates to Madison State Hospital under Criminal Sexual Psychopath Law", R. E. Snodgrass, student interne; movie, "Surgical Operation to Correct Hermaphroditism", courtesy of Dr. Allen Howard, Los Angeles; "Bisexuality, Psychological and Anatomical", Dr. Wm. Ellsworth Murray, clinical director, Madison State Hospital.

The discussion was opened by Dr. George P. Wyman, superintendent and chief medical director, Central State Hospital, Lakeland, Kentucky.

A business meeting followed the main program.

A business discussion followed the first dinner of the fall at the September 11 meeting of the **Floyd County Medical Society** in the New Albany Country Club. Dr. F. K. Allen, secretary, brought mail received during the last several weeks to the attention of the 25 members present.

Dr. Oglesby Paul, Chicago, was the guest speaker at the September 17 meeting of **LaPorte**

County Medical Society in Willard's restaurant, Michigan City. He spoke on "Treatment of Congestive Heart Failure".

At the business meeting which followed Ernest Messner, who recently retired as secretary of the Michigan City Y.M.C.A. after 34 years service, was employed as a part-time lay secretary for the society. Thirty-five members attended. Executive committee meetings of the LaPorte County Society were held on September 8 and 15.

A luncheon meeting of the **Lawrence County Medical Society** was held in Dunn Memorial Hospital, Bedford, on October 7 with 17 members attending. Marion Beard, M.D., the regional director for the Red Cross blood bank, located at Louisville, spoke on "Blood Transfusions." A business meeting followed.

Montgomery County Medical Society members heard Dr. Glenn W. Irwin, Indiana University School of Medicine, Indianapolis, talk on "The Relative Value of Surgery, Anti-Thyroid Drugs and Radio-active Iodine in the Treatment of Goiter" at a meeting held August 20 in Culver Hospital, Crawfordsville. Dinner was served preceding Doctor Irwin's talk. It was announced that the society would cooperate in the diabetic detection drive to be conducted in Indiana in November.

Dr. John H. Warvel, Indianapolis, presented a paper on "Management of the Surgical and Obstetrical Diabetic" at a meeting of **Putnam County Medical Society** in the DePauw Union Building, Greencastle, October 9. Dinner was served to 15 members and two special guests. Robert Amick, I. S. M. A. field representative for southern Indiana, discussed the annual convention, urging members to attend.

Five members of **Ripley County Medical Society**, two guests and members of the Woman's Auxiliary held a dinner meeting in Lakeside Country Club, Milan, October 9. The county health nurse discussed audiometer studies of the school children in the county and a general discussion followed of

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the resolutions which were to come before the House of Delegates at the annual meeting at French Lick.

A business session marked the first fall meeting of the **Shelby County Medical Society** in the Major Hospital, Shelbyville, on September 9. Sixteen members attended the dinner meeting. The diabetes detection drive, formation of a County Health Council, and plans for future meetings were discussed.

Reports of several meetings of the **Tippecanoe County Medical Society**, covering meetings in May, June and July have been made by the secretary, Ramon B. DuBois, M.D. At the May 12 meeting, 37 members and 5 guests heard Dr. William B. Ford, Pittsburgh, discuss "Cardiac Surgery". Previously, at a business meeting, Dr. H. E. Klepinger was named local chairman of the Medical Education Foundation drive, and Dr. J. E. Engeler, was named to serve on the policy committee of the "Third House" of the Greater Lafayette Chamber of Commerce.

"Blood Dyscrasias" was the title of the paper presented at a June 9 meeting of the society by Dr. Robert J. Rohn, Indianapolis. A resolution on the death of Dr. Robert Wagoner was read.

A special business meeting was called for July 7, however, no definitive action was taken.

Dr. Robert M. Salassa of the Mayo Clinic, Rochester, Minnesota, was the scientific speaker at the October 13 dinner meeting of **Vanderburgh County Medical Society** in the Hotel McCurdy, Evansville. He presented a paper on "Diagnosis and Treatment of Adrenal Cortical Insufficiency." Doctor Salassa is a consultant in medicine, section on metabolic diseases, at Mayo Clinic and is instructor in the graduate school at the University of Minnesota.

At the September meeting of Vanderburgh society a plan developed by the Committee on Indigent Care was presented by Dr. R. Case Hammond, chairman. The society approved the proposal which would limit the number of calls welfare recipients may receive from doctors unless special authorization provides otherwise. Two new members have joined the society, Dr. John H. Wolaver and Dr. Milton H. Anderson.

Separate business meetings of the **Dubois County Medical Society** and the Woman's Auxiliary were held following a joint dinner meeting of the two groups in the Huntingburg Country Club on October 8. Twenty-six doctors and auxiliary members were present.



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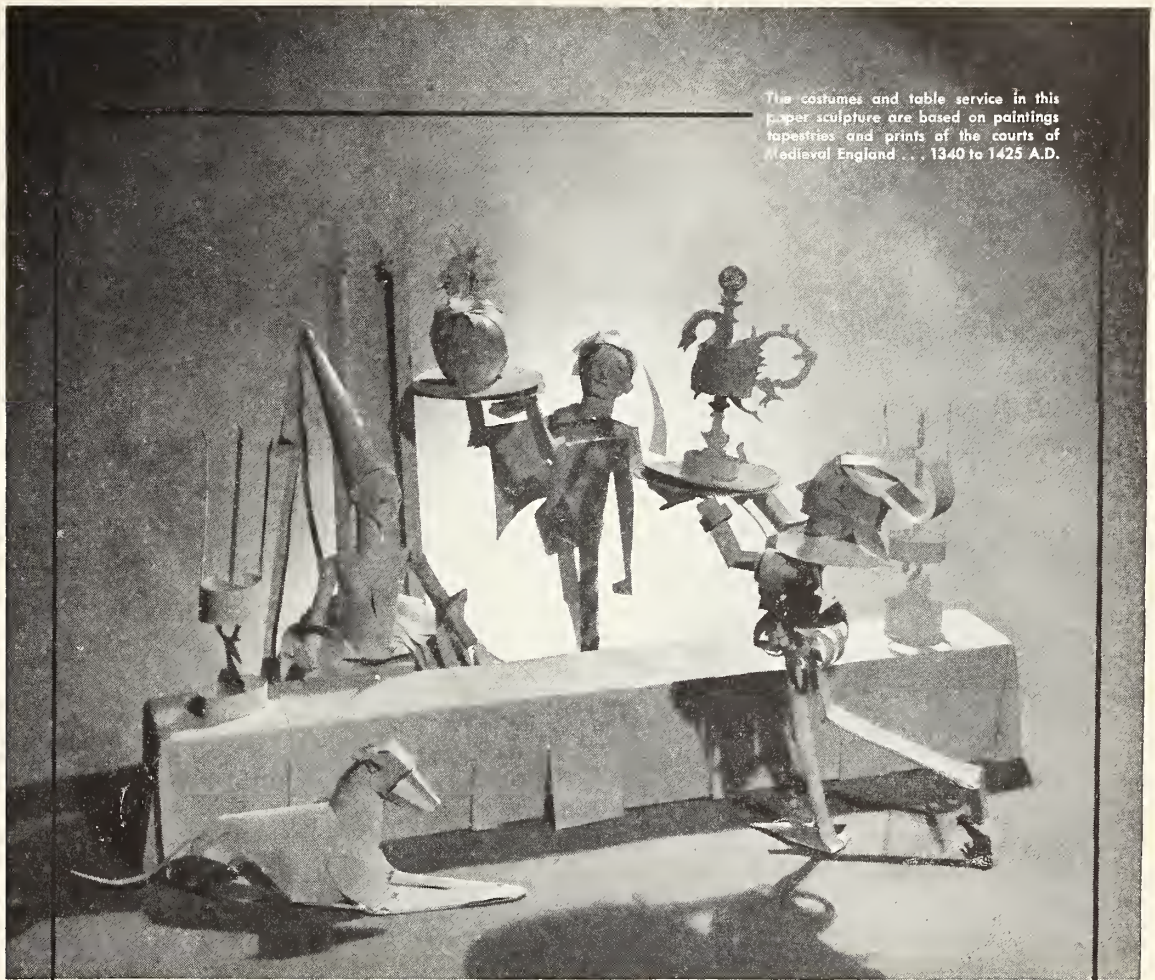
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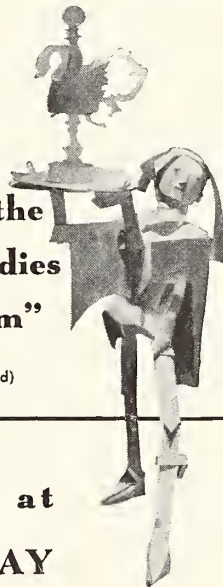


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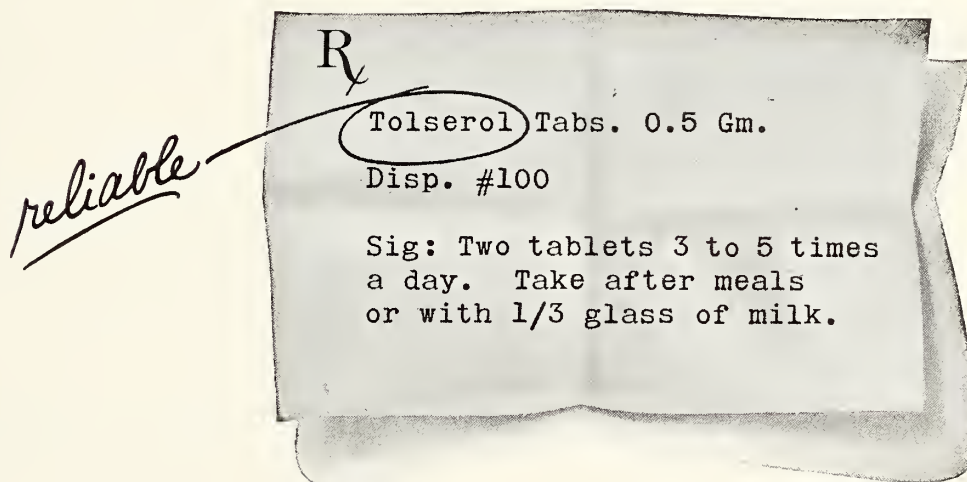
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DR. JONAS E. SALK TELLS OF PROGRESS IN DEVELOPMENT OF POLIO VACCINE

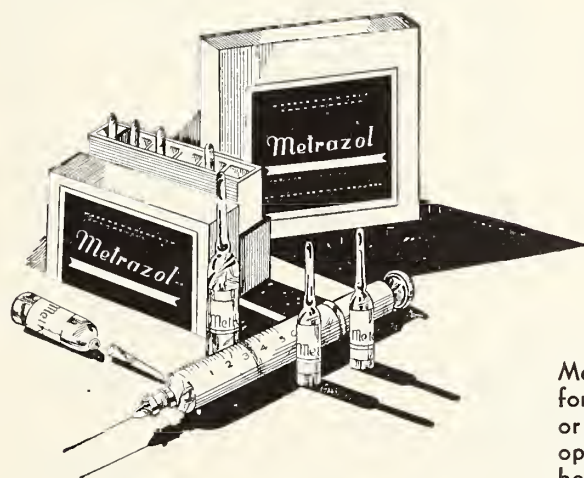
Further progress in the development of a practical polio vaccine has been reported by Dr. Jonas E. Salk, research professor of bacteriology at the University of Pittsburgh School of Medicine.

In an interim report made to hundreds of the nation's child specialists at the 22nd annual meeting of the American Academy of Pediatrics, Dr. Salk disclosed that on the basis of present findings "there may be several possible methods of producing a safe and effective vaccine against polio."

The Pittsburgh scientist, whose studies are being supported with March of Dimes funds from the National Foundation for Infantile Paralysis, revealed that an additional 474 chil-

dren and adults have been vaccinated with several experimental vaccines. The vaccines used have proved to be completely safe and capable of stimulating the production of polio antibodies.

The vaccines used in the study stimulated the production of antibodies within a few weeks after vaccination, Dr. Salk said. Most of those in the new group have been under observation for three to four months and the trends thus far suggest persistence. In a small group of the earlier series, under observation for about seven months, there has been little or no decline. Dr. Salk explained that observations have not continued long enough to make conclusive statements on persistence of antibodies.



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Instruction in interpersonal relationships in the care and management of patients will be emphasized in all Army Medical Service training programs, it has been announced by Maj. Gen. George E. Armstrong, Surgeon General of the Army.

More often referred to as the "doctor-patient relationship", the scope of the concept within the Army Medical Service has been broadened to include all members of the medical team handling patients.

"Courtesy, consideration and sympathetic approach" have become the key words describing the Army Medical Service's concept of the proper relationship between the medical team and the patients on all levels. So important does the Army Medical Service consider the interpersonal relationships between medical teams in treatment facilities and the patients committed to their care that General Armstrong recently called together a panel to discuss means of overcoming problems incident to interpersonal relationships.

The panel recommended that "Specifically, in all courses taught in our hospitals, the Army Medical Service Graduate School, the Medical Field Service School and the Medical Replace-

ment Training Center there will be included additional instructional hours on the principles and practice of interpersonal relationships. Constant emphasis will be placed on the subject. Thus, the idea will be stressed at all levels of training."

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Each inquiry about possible locations is answered by mailing the brochure, "A Home of Your Own Is Awaiting You in Indiana" to the prospect. A letter of welcome is enclosed. To the communities which seek doctors, the Physician Placement Service sends a frequent list of those doctors who have made inquiry, with the suggestion a letter should be sent to the doctors by some group or individual.

Communities which have indicated recently that they need the services of a resident physician are:

DE MOTTE (Jasper County); population 1,866; contact Mr. Alfred Ewart, real estate and insurance, De Motte, Indiana.

LEAVENWORTH (Crawford County); population 394; contact Mary Gibson, Leavenworth, Indiana.

SALEM (Washington County); population 3,194; contact Ernest T. Nuckles, Mayor, Salem, Indiana.

SULLIVAN (Sullivan County); population 5,077; contact Mrs. C. S. Briggs, or Dr. James B. Maple, Sullivan, Indiana.

Doctors who have asked for information about openings in Indiana are:

Gunter A. Lamm, M.D. (general practice), 3274 Giegerich Place, Bronx 61, N. Y.

George A. Kremers, M.D. (urology), 307½ Hill Street, Dubuque, Iowa.

Roscoe Faulkner, M.D. (general practice), Stibnite Hospital, Stibnite, Idaho.

Milton T. Smith, M.D. (general practice), Box 463, Hempstead, N. Y.

Joseph A. Thomas, M.D. (general practice), Timpson, Texas.

Robert C. Bolin, M.D. (internal medicine), Minneapolis VA Hospital, 54th Street and 48th Avenue S., Minneapolis 17, Minnesota.

Arthur C. Maimon, M.D. (pediatrics), 1639 Western Avenue, Warren Heights, Cheyenne, Wyoming.

Vernon V. Bass, M.D. (obstetrics and gynecology), 916 Adams Street, Saginaw, Michigan.

Raymond K. Kincaid, M.D., General Hospital, Indianapolis 7, Indiana.

Allen W. Aldred, M.D., 349½ Limestone, Indianapolis, Indiana.

Carl R. Dudeck, M.D. (general practice), 214 Hummel Avenue, Lemoyne, Pennsylvania.

Capt. Dwight J. Brown, Jr., M.C. (obstetrics and gynecology), OIC, Obstetrics and Gynecology, 3320th Medical Group, Amarilla Air Force Base, Texas.

A. B. Brotman, M.D. (dermatology), 263 Chance Drive, Oceanside, Long Island, N. Y.

G. H. Collings, Jr., M.D. (industrial medicine), 417 N. Pine Street, Florence, Alabama.

Paul E. Hooley, M.D., 750 N. Tibbs Avenue, Indianapolis, Indiana.

H. Clair Amstutz, M.D. (general practice), 521 S. Main Street, Goshen, Indiana.

A. Roxane Palmieri, M.D., 114 Clinton Street, Brooklyn, N. Y.

Robert F. Walter, M.D. (general practice), 537 Hayes Street, Apt. No. 6, Gary, Indiana.

R. D. Haire, M.D. (general practice), R. R. 13, Lima Road, c/o Frank Finkhousen, Fort Wayne, Indiana.

John C. Carmen, M.D. (thoracic surgery), Charles S. Wilson Mem. Hospital, Johnson City, N. Y.

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Medical Panorama—

A. W. Cavins, M. D.
Associate Editor

THE "SHOW ME" STATE

Here's the way things are in Missouri. Just read, below, a page taken from the *St. Louis County Medical Society Bulletin* for Sept. 25, 1953. Thank goodness we don't have anything like this in Indiana,—or do we?

THESE THINGS DON'T JUST HAPPEN

Some members of any organization, especially in medical groups, seem to think merely by paying their dues they have fulfilled all their obligations. As a corollary, these same members assume that, having sent in their money, "they" will do the rest of the job! And, to compound the impasse achieved by such sterile thinking, they figure everything will run more or less spontaneously and automatically without effort or sacrifice.

"Why," they'll reason, "that bunch of medical politicians down there, they run things. They don't need my help—besides, if I did try to do something they'd run it their own way anyhow." Having thus dealt with this situation (to their own complete and final satisfaction), our medical colleagues consider the matter closed, finished, kaput! Yet, these same members will be the first to sound off when some action is taken by the society with which they are in disagreement. Probably they know nothing of the issues involved, have made no effort to find out the true facts. They could have informed themselves merely by reading their mail—this is the type which we all recognize as the flagrant foot-dragger.

These voluble members, with an overwhelming burden of physical and mental inertia, are the first to criticize and the last to pitch in and do a

job, even to find out what's going on, concerning their medical organization.

Not all the fellows who work on medical organization affairs have sordid, grasping ambitions, perhaps some few have. But, in the main, most of the guys who really work are just ordinary fellows who gripe, groan, and cuss, but get the job done, with a normal pride in their results.

The next time you hear some member vehemently denouncing something that's going on in your society, just ask yourself: Does he really know what he's talking about, has he spent even two minutes trying to find out all the facts, would he have lifted his little finger if appointed to do the job? Just ask yourself these questions, and usually you'll find, in inverse proportion as he rants and raves, will the same member deliver the goods. He hasn't learned—These Things Don't Just Happen!

VINCENT T. WILLIAMS, M.D., *Editor*,
MISSOURI MEDICINE (Journal of the
Missouri State Medical Assn.)

Cancer Seminar to Be Presented at Phoenix

Dates for the Second Annual Cancer Seminar of the Arizona Division of the American Cancer Society have been set for January 14, 15 and 16, 1954 at Phoenix, Arizona, according to Dr. Edward H. Bregman, chairman.

Arizona men will serve as moderators for panel discussions by noted specialists from throughout the United States.

Write for reservations to the Arizona Division, American Cancer Society, 1429 North First Street, Phoenix, Arizona. All sessions will be held in Paradise Inn.

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Medical-Dental Management

September 28, 1953

Editor,
The Journal of the Indiana State
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23 East Ohio Street
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When doctors in your area must prescribe a mild climate and good care for certain of their patients, they may be glad to know that Arizona now has a rigid licensing law for nursing and rest homes, and that our state health department has adopted strict regulations covering their operations.

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The Association will gladly cooperate with your doctors and the families of their patients in finding appropriate accommodations for patients who will benefit from the mild, healthful climate of Arizona.

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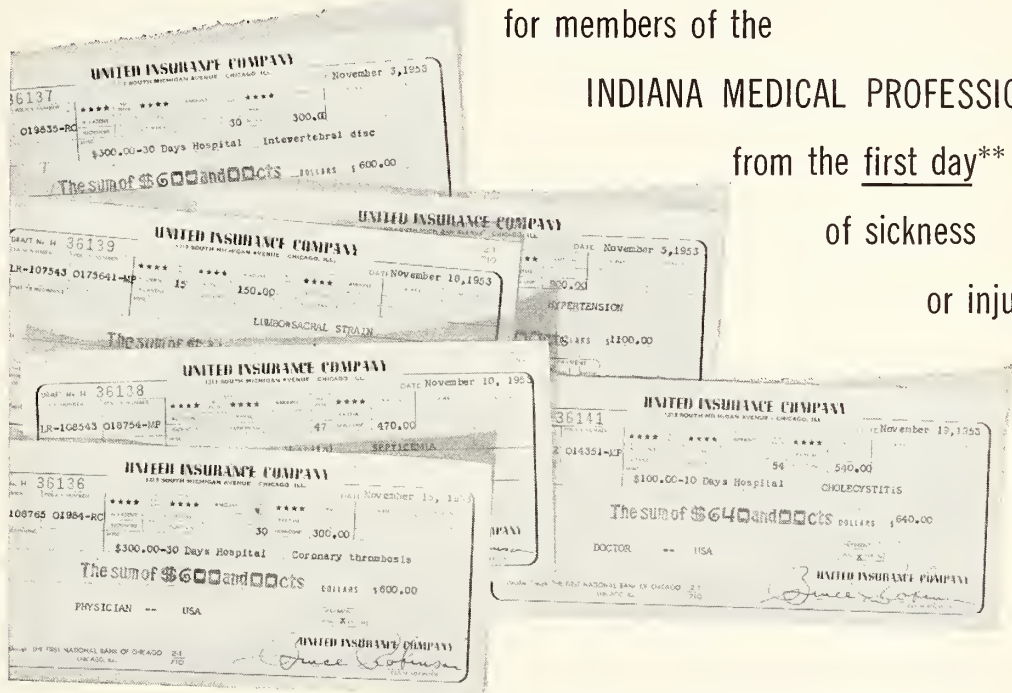
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Books

BOOK REVIEW

SYPHILITIC OPTIC ATROPHY. By Walter L. Bruetsch, M.D. American Lecture Series. Chas. C. Thomas, Springfield, Illinois. 138 pages. Price \$5.50.

This monograph is the first publication to appear devoted exclusively to syphilitic atrophy of the optic nerve. It is concerned primarily with the pathology and pathogenesis although the clinical symptoms, treatment and prevention are discussed. Emphasis is

given to early detection and treatment to prevent a visual disaster which accounts for from 10-15 percent of blindness.

The author bases his conclusions on pathological examination of the nerve tissue and pathways of eighty patients from a large mental hospital. The material supports the conclusion of Leri that syphilitic atrophy of the optic nerve and pathways is an interstitial neuritis.

Dr. Breutsch has done an excellent work. The monograph should be in the library of every neurologist and ophthalmologist.

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SYNOPSIS OF PATHOLOGY. W. A. D. Anderson, M.D., Pathologist, Marquette University. 788 pages, 334 text illustrations, 13 color plates. Third edition. C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Mo. Price \$8.00.

For an every day desk reference book on pathology, nothing could surpass this in completeness and conciseness; with descriptions and illustrations of hundreds of neoplasms. However, it is essentially a synoptic index from which one must turn to Dr. Anderson's major volume and to the up to the minute bibliographies, the latter including only English written papers in readily accessible journals. It is an indispensable diagnostic aid with the latest developments in cytology.

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Books

BOOKS RECEIVED

Books received are acknowledged in this column, and such acknowledgement must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

SYNOPSIS OF PEDIATRICS. By John Zahorsky, M.D. and T. S. Zahorsky, M.D., Department of Pediatrics, St. Louis University School of Medicine. 470 pages, 158 text illustrations, 9 color plates. Price \$6.00. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Mo. 1953, Sixth edition.

MANAGING YOUR CORONARY. By William A. Brauns, M.D., senior attending physician, Michael Reese Hospital, Chicago. 158 pages, with illustrations. Price \$2.95. J. B. Lippincott Company, East Washington Square, Philadelphia, Pa.

DISEASES OF WOMEN. By Robert James Crossen, M.D., assistant professor of clinical gynecology and obstetrics, Washington University School of Medicine, St. Louis. Tenth edition, 935 pages, 990 illustrations, 41 in color. Price \$18.50. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Mo. 1953.

CURE YOUR NERVES YOURSELF. By Louis E. Bisch, M.D., psychiatrist and noted writer. 247 pages. Price \$3.50. Wilfred Funk, Inc., 153 E. 24th St., New York 10, N. Y.

PEPTIC ULCER. By Lucian A. Smith, M.D., and Andrew B. Rivers, M.D., (deceased), Division of Medicine, Mayo Clinic, Rochester, Minnesota. 576 pages, fully illustrated. Appleton-Century-Crofts, Inc., New York. 1953.

LIVING WITH A DISABILITY. By Howard A. Rusk, M.D., Director Institute of Physical Medicine and Rehabilitation. 207 pages, 275 illustrations. Price \$3.50. The Blakiston Company, Inc., Garden City, New York. 1953.

MAY'S MANUAL OF DISEASES OF THE EYE. Edited by Charles A. Perara, M.D. Twenty-first edition. 512 pages, 378 illustrations, 93 color figures. Price \$6.00. The Williams & Wilkins Co., Baltimore 2, Maryland. 1953.

RESPIRATORY DISEASES AND ALLERGY. Joseph S. Smul, M.D., New York. 80 pages. Price \$2.75. Medical Library Co., 232 East 15th St., New York 3, N. Y.

HOLT PEDIATRICS. Twelfth Edition. By L. Emmett Holt, Jr., M.D., professor of pediatrics, New York University College of Medicine, and Rustin McIntosh, M.D., Carpentier Professor of Pediatrics, Columbia University. 1483 pages, fully illustrated. Appleton-Century-Crofts, Inc., New York. 1953.

ENDOCRINOLOGY IN CLINICAL PRACTICE. Edited by Gilbert S. Gordon, M.D., assistant professor of medicine, University of California School of Medi-

cine; and H. Lissner, M.D., clinical professor of medicine and endocrinology, University of California School of Medicine. 407 pages, well illustrated. Price \$10.50. Year Book Publishers, Inc., 200 East Illinois St., Chicago 11, Ill. 1953.

SURGERY OF TRAUMA. Edited by Warner F. Bowers, M.D., Colonel, MC, U.S.A., with foreword by Melvin A. Casberg, M.D., chairman, Armed Forces Medical Policy Council. 605 pages, 284 illustrations. Price \$15.00. J. B. Lippincott Company, East Washington Square, Philadelphia 5, Pa. 1953.

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University of Florida EENT Seminar January 18-23

The eighth annual University of Florida Mid-winter Seminar in Ophthalmology and Otolaryngology will be held at the Sans Souci Hotel in Miami Beach the week of January 18. Lectures on ophthalmology will be presented on January 18, 19 and 20 with Dr. W. B. Anderson, Durham, North Carolina; Dr. W. P. Beethem, Boston; Dr. W. C. Owens, Baltimore; Dr. A. B. Reese and Dr. W. C. Wheeler, both of New York City, giving the lectures.

The Otolaryngology lectures will be given by Dr. E. N. Broyles, Baltimore; Dr. H. P. Houser, Los Angeles; Dr. W. J. McNally, Montreal; Dr. Dorothy Wolff and Dr. D. Woodman, New York City, lecturing on January 21, 22 and 23.

The Florida Society of Ophthalmology and Otolaryngology will hold its midwinter meeting on January 20. All registrants for the seminar may attend, according to Dr. Shaler Richardson, Graduate School of Medicine, University of Florida, Jacksonville.

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Opinions From Here and There

Prepared for your information by the Committee on Public Policy and Legislation of the Indiana State Medical Association

MEDICAL TASK FORCE OF GOVERNMENT REORGANIZATION COMMISSION to be headed by Chauncey McCormick of Chicago has received ten acceptances so far, according to Herbert Hoover, Chairman of the Government Reorganization Commission.

FOOD AND DRUG ADMINISTRATION HAS WON LATEST ROUND in battle against Hoxsey Cancer Clinic, Fifth Circuit Court of Appeals having ordered Judge William Atwell to place an injunction against Hoxsey medicine shipments that will be without favoring loopholes.

MANION COMMISSION ON INTERGOVERNMENTAL RELATIONS selects two committees. The Commission which will presumably make a close study of Public Health Service grants to the various states, established one committee on projects and organization which will be headed by Mrs. Alice K. Leopold, Connecticut Secretary of State. The second is on principles and historical development of Federal government headed by Lawrence Appley, president, American Management Association.

SOCIAL SECURITY HEARINGS STARTED with spokesmen being Federal officials rather than spokesmen for professional and private organizations leading off.

CHAIRMAN CARL CURTIS (R-Neb.) OF THE FACT FINDING SUBCOMMITTEE observed that the hearings are preliminary to consideration early in 1954 by the parent Ways and Means Committee of pending legislation which would extend social security coverage to physicians, dentists and other self-employed persons.

MRS. HOBBY EXPRESSES HER VIEWS stating she expects to see the social security issue receive top priority when Congress reconvenes in January. The proposal for extension of SS coverage has the strong support of President Eisenhower and was presented to Congress in the closing days of the last session, but too late for action.

SPEAKING BEFORE A REPUBLICAN RALLY in Kiamesha Lake, N.Y., Mrs. Hobby said: "This bill (extension of SS) is in line with the President's campaign promises and will, if passed, give social security advantages to more than ten million Americans who at present are left out of the system. These include many self-employed professional people—doctors, lawyers, accountants, dentists, self-employed farm operators, hired farm workers, a large number of household workers not now covered, and possibly four million state and local government workers.

EVIDENTLY IT IS TO BE PRESSED for passage in the coming session of Congress for a few days following Mrs. Hobby's talk at Kiamesha Lake, she spoke before the convention of the American Federation of Labor where she again stated that social security extension would be pressed by the administration.

DENTISTS REJECT PROPOSAL FOR INCLUSION under the Old Age Survivors Insurance Plan and Social Security for the third time since 1949. The ADA House of Delegates expressed opposition to being included under the plans by a vote of 312 to 64, minority strength coming mainly from New England.

ISMA HOUSE OF DELEGATES ADVOCATES active interest on the part of every physician, according to action taken at the French Lick meeting,

in which every physician is urged to work for the passage of the Reed-Keogh or Jenkins-Keogh bill rather than have the profession included in the SS program.

IT IS NOT TOO LATE FOR YOU to do something about this as an individual or as a county medical society. Your Congressman will be home for a few more days, why not take time and look him up to discuss this matter with him, or better still invite him to your society for a meeting with all the members.

SCHOOL KIDS WON'T LIKE THE ACTION of the ADA'S House of Delegates when they urged banning of candy and soda pop sales in schools to curb consumption of sugar, "a hazard to dental health".

MEDICAL DEANS COOLING TO U.S. FINANCIAL AID. Meeting recently in Atlantic City, the increasing resistance to proposed Federal financial aid to medical schools was noticeable. On the basis of a mail ballot survey, results of which were discussed at the meeting, a majority of the Deans still advocate Federal aid for operating expenses.

THIRTY PER CENT OF THE DEANS have changed their minds as the meeting showed only 60 per cent favoring Federal aid, whereas in 1949 9 out of 10 wanted Federal subsidies.

HERE'S ANOTHER ONE TO ADD TO YOUR ALPHABET—"MEND"—it means Medical Education for National Defense. This program which has been sponsored by the Army, Navy and Air Force to the tune of about \$15,000 a year per school, in five of the nation's medical schools, for the purpose of teaching medical preparedness and civil defense. The Dean's Association, after hearing the report of the pilot program, urged that the program be made available to all medical schools on a voluntary basis as rapidly as possible. This program could have some Federal implications.

DR. STANLEY W. OLSEN OF BAYLOR UNIVERSITY and chairman of the MEND committee reported the following conclusions of his committee:

- (1) There is need for modification of medical curricula to make students better able to cope with emergencies of war and disaster. (2) Underlying philosophy of pilot programs "is consistent with sound concepts of medical education." (3) Faculty and student acceptance of MEND is "remarkably good." (4) Innovation would have been impossible without U.S. financial aid. (5) Cooperation between armed forces and schools has been very good. (6) Medical Education has benefited greatly from close coordination among various branches of armed forces, cooperation of Federal agencies with schools, opportunity afforded faculty members for travel to special conferences, and availability of teaching aids such as motion pictures, special military reports, and technical manuals. Note: California, Cornell, Buffalo, Illinois and Vanderbilt medical schools have introduced MEND.

CLOSED DOOR SESSIONS OF STATE AND TERRITORIAL HEALTH OFFICERS meeting in Washington are expected to supply representatives with information on severe reductions that were made in government's budget for current year affecting state aid for public health services; experimental vaccination program to be launched early next year by National Foundation for Infantile Paralysis; administrative reforms in Washington which are producing side reactions in state health departments.

FEDERAL TRADE COMMISSION HAS ENTERED INTO AN agreement with "TUMS" who will discontinue advertising claims relating to its efficacy against gastric acidity.

HOW MUCH DOES IT COST TO OPERATE YOUR AUTOMOBILE? A nationwide survey by the American Automobile Association discloses the annual cost of an automobile when operated 10,000 miles to be \$908 for over-all upkeep and expense. Expenses included fire and theft, property damage and liability insurance, license fees and depreciation.

THESE FIXED ITEMS TOTALED \$559 to which was added \$348 as the annual cost of gasoline and oil, maintenance and tires. Depreciation is commonly figured at 2 to 2½% a month for an average of 25% a year.

THE COMPUTATION MADE BY A CHICAGO COST ACCOUNTING firm is of value to physicians who maintain an automobile for use in their practice. Cost of operating a car in this connection is deductible as an expense in computing federal income tax.

HOUSE HEALTH HEARINGS UNDERWAY before House Interstate Commerce Committee with Rep. Charles A. Wolverton (R-N.J.) serving as chairman.

INTRODUCTORY STATEMENT PINPOINTS COSTS. Rep. Wolverton placed emphasis on economic burden imposed by chronic and disabling illness, particularly with reference to loss of working time. "Apart from the human factors involved," he said, "I have become convinced from my study of health problems that the subject of health has more important economic implications for our nation than many of the economic activities which are subject to Federal regulatory legislation."

REP. WOLVERTON LEFT NO DOUBT that he feels something must be done, perhaps with Federal participation, to bring competent medical care more within the reach of citizens who cannot afford to pay big doctor bills, "if we have to reconcile ourselves to living in the shadow of many of these major diseases for some time to come, the question that we would like to ask is how we can provide protection against the economic consequences of these diseases," he said.

TWO NATIONALLY PROMINENT PHYSICIANS joined Rep. Wolverton in acknowledging that serious attention must be given financial problems of the medical care consumer. Dr. U. R. Bryner, president of the American Academy of General Practice, told the District of Columbia Medical Society that socialized medicine will certainly ensue if fees become exorbitant. At the same assembly, AMA President E. J. McCormick called for maximum participation in medical care insurance plans. Two days later Rep. Wolverton reemphasized his increasing anxiety over rising costs of diagnosis and treatment.

THE PROTECTION AVAILABLE AGAINST LARGE MEDICAL EXPENSES resulting from extended illness, is the matter with which the committee is particularly concerned, stated Rep. Wolverton. "If there are any obstacles which stand in the way of broadening and improving existing methods of voluntary protection, I want to know all about them because I believe firmly that the American people need better protection against the staggering economic burden resulting from extended illness."

IVES-FLANDERS TYPE OF BILL INTERESTS HOUSE COMMITTEE. Most frequently mentioned piece of legislation in the Committee hearings is the Ives-Flanders type bill which provided, among other things, for Federal grants to aid states in financing voluntary prepayment plans.

CHAIRMAN WOLVERTON AS FAR BACK AS 1950 was supporting the idea of some form of Federal backing for voluntary health plans. In the 81st Congress, he introduced a bill for a Federal Reinsurance Corporation with capital stock of 50 million, it provided the mechanism for non-profit plans

to buy reinsurance from the government. The latter, in turn, would reimburse the plans to the extent of two-thirds of individual medical cost claims in excess of \$1,000.

CATASTROPHIC INSURANCE IS GROWING. At the end of 1952 more than 156,000 persons were covered by this type of insurance, which complements the usual hospitalization, surgical and medical policies by paying 70 or 80 percent of the additional cost up to a usual maximum of \$10,000. Edmund Whittaker, vice president of Prudential Insurance Company, estimates that now about one million persons are covered for catastrophic illness and that experience demonstrates that "everybody wants this coverage."

PUBLIC RELATIONS TRAINING URGED FOR MEDICAL STUDENTS in action taken by the House of Delegates of the New York Medical Society (State). Letters addressed to all medical schools in New York state by the Society stated it hoped all medical students, interns and residents "will be impressed with the importance of the public relations of the medical profession." "A sympathetic attempt to understand every patient's psychiatric problem as well as his or her disturbed physiology is of the utmost importance."

ONONDAGA (NY) COUNTY MEDICAL SOCIETY revised its Emergency Call Service requiring all physician members under 50 and specialists to serve on the panel. The NY State Society calls attention to the article in the August issue of Medical Economics, which told how the society wrote off the old emergency call service as a flop, as "must" reading for any society having difficulty carrying on a voluntary emergency call service.

TO ALL MY PATIENTS, a small pamphlet prepared by Dr. Walter L. Portteus, Franklin, president-elect, for distribution to his patients whom he refers to the hospital received recognition by the AMA. Dr. Lull, AMA secretary, congratulated him for his good public relations endeavor, in the AMA Secretary's Letter.

DR. TURNER TAKES OVER AS COUNCIL SECRETARY. Formerly dean of the School of Medicine and chairman of the Division of Health Sciences of the University of Washington, in Seattle since 1945, Dr. Edward L. Turner has taken over his new job as secretary of the AMA Council on Medical Education and Hospitals. Dr. Donald G. Anderson left the post on October 1 to become director of the medical center and dean of the School of Medicine of the University of Rochester.

AMA STATES VA IS HOSPITALIZING MORE NON-SERVICE connected cases. Latest statistics from Veterans' Administration show the agency is reducing its lists of service and non-service connected cases awaiting hospitalization. In August 1952 service connected cases waiting admission totaled 143. During July and August of this year they numbered only two. At the same time VA is getting more and more non-service connected cases into its hospitals. In August 1952 VA listed as waiting hospitalization 22,431 cases it described as "other than disabilities adjudicated service-connected." By July of this year only 20,370 were still waiting treatment, and in August only 17,874.

VETERANS' LIAISON COMMITTEE MET WITH THE VETERANS on November 18, and this was written prior to that date. It is expected, however, that the Legion will endorse the action taken by the ISMA House of Delegates in approving the report of the Veterans Committee. If this should happen, the medical profession of Indiana and the Indiana Department of the American Legion will have a working agreement which in time should solve the problem as far as Indiana is concerned.

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THE EFFECT OF COBALT-IRON THERAPY IN IRON DEFICIENCY ANEMIA IN INFANTS

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Introduction

HERE has recently been a great deal of interest in the use of cobalt as a therapeutic agent in various forms of anemia. It has long been known that cobalt will produce a polycythemia in laboratory animals¹ but prior to 1949, only a few reports concerning its use in human anemia have appeared^{2, 3, 4, 5, 6}. It remained for Robinson, *et al*⁷ and Berk, *et al*⁸ in this country and for Wolff⁹ and Weissbecker¹⁰ in Germany, to conduct the preliminary investigations which have pointed the way to the possible extensive clinical usefulness of this element in human therapy.

The independently discovered facts that the Vitamin B₁₂ molecule contains a cobalt moiety

and that certain animal anemias are, in fact, a cobalt deficiency led to the assumption, for a time, that cobalt exerted its hemopoietic effect through an *in vivo* synthesis of cyanocobalamin. Although this is true in certain animal species¹¹, it is not the case in man. This fact became evident when it was shown that cobalt not only had no hemopoietic effect in any of the human macrocytic or megaloblastic anemias, but that its effects were pronounced in those hypochromic anemias, in both man and animal, where cyanocobalamin was ineffective.^{12, 20}

The primary effect of cobalt, in therapeutic dosage, appears to be a specific stimulating action on the hemopoietic system. Thus, Kato¹³ reported an increase in erythroid tissue in cobalt treated animals; both Wolff¹⁴ and Weissbecker¹⁵ reported an increase in the number of mitotic figures in the bone marrow. More recently, Seaman¹⁶ found striking increases in the erythro-genic bone marrow elements and Gardner¹⁷ re-

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† This study was aided by a grant from Lloyd Brothers, Inc., Cincinnati, Ohio, and materials used were supplied by them.

ports "four of the patients had a distinct increase in the percentage of erythroid precursors."

These effects of cobalt administration seem to be promptly manifested in the peripheral blood by the appearance of a pronounced reticulocytosis¹⁴ and a subsequent parallel increase in erythrocytes and in hemoglobin¹². The actual mechanism of the "cobalt effect" is still obscure.

Cobalt in Normochromic Anemia. The use of cobalt in the normochromic, normocytic anemias which accompany chronic inflammatory disease or systemic infection has been favorably reported^{7, 12} and Gardner¹⁷ has recently shown it to be effective even in the anemia which accompanies chronic renal disease. The evaluation of cobalt therapy in these conditions is relatively simple, since iron reserves either are or may be made to be adequate and the problem is essentially one of initiating or increasing the conversion of iron to hemoglobin. The results of Gardner¹⁷ and others^{7, 12} seem to indicate that cobalt offers great promise in this type of anemia.

Cobalt in Iron Deficiency Anemia. On the other hand, the evaluation of the effect of cobalt in the iron deficiency anemias is more fundamental but more difficult. This is because unless iron is supplied, hemoglobin cannot be formed under the influence of cobalt; yet, these anemias also respond to iron administration alone. Obviously, such an evaluation could be valid only if the hemopoietic effect of simultaneous cobalt-iron administration could be compared with that from iron medication alone.

We have recently reported¹⁸ the results of the administration of a cobalt-iron preparation* to a group of 23 infants and children with well authenticated iron deficiency anemia. It is the purpose of this paper to report our analysis of these clinical findings in comparison with iron therapy in iron deficiency anemia, and to discuss the significance of some of these findings.

The Mechanism of Hemopoiesis. In hemopoiesis, the rate of erythropoiesis is not solely dependent upon hemoglobin synthesis or upon serum iron, since high normal erythrocyte levels are often seen even in the severe hypochromic case of iron deficiency anemia. On the other hand, total hemoglobin cannot exceed that represented by normochromia of the number of cells

present, so that the erythrocyte count is, in fact, the limiting factor. In iron deficiency anemia, this fundamental fact is often disregarded, since iron therapy stimulates erythropoiesis, and the increase in hemoglobin values is often considered to be the best guide to the severity and response to treatment¹⁹.

Striking evidence that neither iron nor hemoglobin synthesis are necessary to cause erythropoiesis is given by recent investigations. Thus, Wolff¹⁴ has shown that, in patients with an exhausted iron reserve, cobalt therapy will produce dramatic erythrocyte increases with a simultaneous decrease in hemoglobin formation; and Crafts²⁰ has maintained erythrocytes at high levels, in hypophysectomized animals, with greatly decreased hemoglobin levels, even in the presence of adequate iron.

The classical response to iron therapy, in iron deficiency anemia, is first a reticulocytosis, followed by an increase in erythrocytes which precedes but progresses relatively more slowly than a subsequent progressive rise in hemoglobin levels. Clearly, these changes may be considered to represent a primary stimulating effect upon the cytopoietic phase of hemopoiesis and a subsequent physiologic utilization of iron. In this concept, the utilization of iron would be dependent upon erythropoiesis unless other agents could be found which would stimulate hemoglobin formation either independently or concurrently.

The work of Crafts²⁰ and of Garcia, *et al*²¹, makes it appear that cobalt stimulates both hemopoietic processes simultaneously, since cobalt administration in animals not only maintains erythrocyte production more effectively than other selective cytopoietic stimulants but also results in the production of hemoglobin values which could not be obtained with other therapeutic substances.

In our hands, the administration of cobalt-iron preparations in the pure iron deficiency anemias of infants and children follows the same pattern. Erythropoiesis is stimulated to levels far greater than the expectancy from iron administration alone; hemoglobin synthesis is maintained near what appears to be the physiologic maximum, regardless of the severity of the anemia. This latter fact results in greatly increased utilization of iron, especially in the lower grades of hypochromic anemia, where the response to iron alone is relatively slight.

* Supplied by Lloyd Brothers, Inc., as Roncovite. Each 0.6 cc. contained 40 mg. of cobalt chloride and 15 mg. of elemental iron as ferrous sulfate.

The Effect of Cobalt on Erythrogenesis

The pre-occupation with hemoglobin changes and the presumed inherent inaccuracy of erythrocyte enumeration has led to a paucity of data in the literature as to the degree of erythrogenesis to be expected from iron therapy in iron deficiency anemia. It is generally accepted, however, that increases of 250,000 erythrocytes per week is a satisfactory response, although the rate of increase may tend to level off as the normal is approached²². In a careful study of this subject, Schiødt²³ established an interesting mathematical relationship between the rate of erythrocyte increase to be expected from iron administration and the severity of the initial iron deficiency anemia. He found that, except for a minor rate decrease at the higher levels, 33 days was required to restore the erythrocyte count to 4,500,000 cells per cmm. regardless of the initial level and that the rate of increase was a straight line relationship. Increases above this value were slow and difficult to obtain. Using Schiødt's calculation, and assuming beginning levels of 3,000,000 to 3,500,000 erythrocytes per cmm., good agreement exists between the calculated rate of increase and the empirical expectancy value of 250,000 cell increases per week.

With the administration of the cobalt-iron preparation, however, we found that our weekly erythrocyte increments far exceeded, in most cases, such expected increases. Since the iron content of our preparation was below what is usually considered to be optimum dosage, it is apparent that the greatly accelerated erythropoiesis must be due to cobalt administration. Comparative results are shown in Table 1.

From the data in Table 1, we concluded that cobalt-iron therapy, at the dosage levels used, was considerably more powerful as an erythropoietic stimulant than is iron alone and that the increased effect must be due, of necessity, to the cobalt factor. In fact, based on the empirical increment expectancy of 250,000 cells per week, our average gain was about 300% greater; based on Schiødt's data, it was approximately 500% larger.

Reticulocytosis. In iron deficiency anemia, the mild reticulocytosis which is produced by iron administration varies in magnitude with the severity of the anemia. This reticulocytosis is generally accepted to be an indicator of hemo-

TABLE 1*

Comparison of the Erythropoietic Response to Cobalt-Iron Therapy as Compared with the Expected Response to Iron Therapy Alone

Case	Expected RBC increment (approx.) with iron alone (per cmm. per day)	RBC increment with Cobalt-iron therapy (per cmm. per day)
1	68,000	40,000
2	46,500	113,000
3	57,500	74,000
5†	none	79,000
6	14,500	133,000
7	41,000	19,000
8	none	26,000
9	none	100,000
10	none	159,000
11	34,500	155,000
12	none	165,000
13	45,000	68,000
14	45,000	190,000
15	10,000	198,000
16	7,000	42,000
17	7,000	81,000
18	26,000	78,000
19	17,000	134,000
20	none	122,000
21	19,000	77,000
22	none	107,000
23	21,000	134,000
Average	20,850 per day (approx.)	104,300 per day (approx.)
Average gain/week	146,000 (approx.)	730,000 (aprx.)

* Initial hemoglobin and erythrocyte values for these cases are shown in Table 2 and are omitted here for reasons of clarity of presentation.

† Cases where no erythrocyte increases were to be expected had initial counts near 4,500,000 cells per cmm. and the anemia was characterized by low hemoglobin findings (See Table 2 for full data).

poietic stimulation and is so reliable as to form the basis of evaluation of the stimulating properties of various forms of iron. Minot and Heath²⁴ have published data showing the response to be expected from iron administration at various initial levels of both hemoglobin and erythrocytes.

Obviously, if the simultaneous administration of cobalt and iron produces a greater degree of reticulocytosis than does iron alone, then it is additional evidence that cobalt has a stimulating action, over and above that of iron, on hemopoiesis. Such action is probably erythrogenic rather than being concerned with increased

hemoglobin formation, since reticulocytosis is essentially a cytological phenomenon.

In Table 2 we have compared the peak reticulocyte response in our series of cases of iron deficiency anemia, all under therapy with cobalt and iron, against the values to be expected as based on the Minot and Heath standards²⁴, for iron therapy alone. The comparison of "averages" shown in columns 8 and 9 follows the procedure of these authors.

If we consider a difference of 2% or more in the reticulocyte count as having significance, it will be seen from Table 2 that, based respectively on the initial hemoglobin, the initial erythrocyte count and the initial average, then 11, 16 and 13 patients of the group of 23 showed a greater reticulocytosis with cobalt-iron therapy than would have been expected with iron alone. The overall average for the 23 cases showed an expectancy of 5.4% reticulocytes with iron therapy alone, as compared with that of 8.4% found with the cobalt-iron preparation.

It is interesting to note that the 2 cases show-

ing smaller than expected erythrocyte increments with added cobalt (cases 1 and 7, Table 1) did not show significantly less reticulocytosis with cobalt-iron than the expected iron response.

Based on our results, we have concluded that although cobalt causes a reticulocytosis somewhat greater than that due to iron, the increases are not sufficiently reliable or consistent to serve as a criterion of the degree of hemopoietic stimulation. This conclusion is not in accord with that of Wolff¹⁴ but it agrees closely with the observations of Gardner¹⁷ on the effect of cobalt in the anemia of chronic renal disease.

The Effect of Cobalt on Hemoglobin Synthesis

The powerful erythropoietic action of cobalt would be of relatively little value in most anemias unless hemoglobin increases also occurred. In iron deficiency anemia, therefore, the value of cobalt would depend, in part, upon increasing the rate of hemoglobin formation.

TABLE 2

Comparison of Reticulocyte Response to Cobalt & Iron as Compared to the Expectancy with Iron Alone²⁴

Case	Initial Hgb. % (15.6 Gm. = 100%)	Expected peak reticulo- cytes at this Hgb. level.	Actual peak reticulo- cytes found	Initial RBC in millions	Expected reticulo- cyte peak at this RBC level	Actual peak reticulo- cytes found	Average peak reticulocytes:	
							Expected	Found
1	54	6 %	9 %	2.25	12 %	9 %	9 %	9 %
2	55	6 %	5 %	2.96	4 %	5 %	5 %	5 %
3	61½	4 %	6 %	2.60	10 %	6 %	7 %	6 %
4	68½	3½%	4 %	4.75	3 %	4 %	3 %	4 %
5	47½	6¼%	6½%	4.48	3 %	6½%	4½%	6½%
6	45	7 %	16½%	4.02	4 %	16½%	5½%	16½%
7	57	5 %	3½%	3.15	5½%	3½%	5 %	3½%
8	59	4 %	9½%	5.25	0	9½%	2 %	9½%
9	38	8 %	6 %	5.42	0	6 %	4 %	6 %
10	57½	5 %	4½%	4.45	3 %	4½%	4 %	4½%
11	26	11 %	10½%	3.36	5 %	10½%	8 %	10½%
12	42	8 %	6 %	4.80	2 %	6 %	5 %	6 %
13	32	9½%	9 %	3.12	6 %	9 %	8 %	9 %
14	20	14 %	23 %	3.02	6 %	23 %	10 %	23 %
15	57	5 %	8 %	4.18	4 %	8 %	4½%	8 %
16	26	6 %	8 %	4.26	3 %	8 %	4½%	8 %
17	40	8 %	10½%	4.26	3 %	10½%	5½%	10½%
18	46	6½%	8 %	3.64	4 %	8 %	5¼%	8 %
19	44	6 %	8 %	3.94	4 %	8 %	5 %	8 %
20	36	10 %	12½%	4.53	3 %	12¼%	6½%	12¼%
21	60	4 %	4 %	3.88	4 %	4 %	4 %	4 %
22	50	6 %	4½%	5.02	0	4½%	3 %	4½%
23	33	9 %	12 %	3.81	4 %	12 %	6½%	12 %

In severe iron deficiency anemia, the fact that the rate of hemoglobin formation increases, up to a maximum value, with increasing dosage of a given iron salt, would indicate that iron is capable of producing the maximum physiologic response. If this is true, cobalt administration could not be expected to increase this rate.

On the other hand, the rate decreases markedly, with iron therapy, as the normal is approached and the percentage utilization of ingested iron falls to low levels. These facts indicate that iron, under these conditions, does not produce the maximum physiologic response and it would be possible for cobalt, or some other therapeutic agent, to stimulate hemoglobin formation and increase the utilization of iron up to the physiologic maximum.

The expected rate of hemoglobin response to iron therapy in iron deficiency anemia has been established for adults by Heath²⁵ and for infants and children by Josephs²⁶.

Heath's dosage of 6.0 gm. of iron and ammonium citrate per day represents 1000 mg. of metallic iron and has been well established as optimal for adults. Josephs used 0.2 gm. of the same compound per kilo per day and, on a weight basis, this is not only more than twice the adult dosage used by Heath, but is considerably greater than dosages often recommended in actual practice²⁷. It has been shown that equivalent results²² would have been expected from ferrous sulfate dosage providing 180 mg. elemental iron by Heath, or 6 mg. elemental iron per kilo by Josephs. On an age-weight basis, this corresponds to a daily intake of about 60 mg. of elemental iron, as ferrous sulfate, in Josephs' series. Such a dosage is recommended for infants and children by Wintrobe²⁸.

The results obtained by Heath and by Josephs are in excellent agreement for the rate of hemoglobin response until values reach about 7 gm. of hemoglobin per 100 cc. Above this value, Josephs, in infants and children, found a sharp decrease in the rate of hemoglobin increment.

In our series of cases, we gave 0.6 cc. of the cobalt-iron preparation 3 times daily to infants and children with pure iron deficiency anemia. This dose provided approximately 45 mg. of elemental iron per day, as ferrous sulfate. Comparison with the data given above indicates

that we were giving relatively less iron, in comparable form, than was used as the basis for the standards proposed. Consequently, in our work, any hemoglobin response greater than expected *could not be ascribed to the iron we administered, but would have to be due to the cobalt.*

For comparative purposes, we treated our results in the 16 cases for which data were available, by the identical statistical method developed by Josephs and used also by Heath. Briefly, this consists in plotting the hemoglobin increase against time for each case, drawing a curve of best fit and reading the days required for hemoglobin to rise through an arbitrary increment from the curve as extrapolated to the nearest $\frac{1}{2}$ gm. of hemoglobin. The mean of the time increments is then plotted against hemoglobin to obtain a composite graph. Our data appear in Table 3 and Chart 1. As recommended by Heath and Josephs, we disregarded the preliminary lag period which often occurs at the beginning of iron therapy but it is interesting to note that no such lag existed in 9 cases, two showed a 1 day lag period and the maximum period of 5 days occurred in only 2 instances. This is in contrast to the 3 to 6 day preliminary lag period usually experienced with iron alone.

Chart 1 shows that cobalt-iron therapy was as effective as was presumably optimal iron therapy for values up to about 7 gm. of hemoglobin per 100 cc. of blood. Above this, however, the rate greatly exceeded Josephs' values as determined for iron alone. This may be interpreted as follows: Cobalt does not increase the maximum physiologic utilization of iron but it tends to maintain iron utilization at the maximum physiologic rate. In this latter respect it is superior to iron.

The composite cobalt-iron graph represents a gain of 9 gm. of hemoglobin in 55 days therapy for an average of 0.164 gm. of hemoglobin per day. Since a 1% rise in hemoglobin (0.156 gm.) per day requires about 25 mg. of elemental iron, this quantity of hemoglobin represents an iron utilization of:

$$0.164/0.156 \times 25 = 26.3 \text{ mg. per day}$$

This utilization was obtained from 45.3 mg. per day administered and this represents, therefore, a percentage utilization of:

$$26.3/45.3 \times 100 = 58\%$$

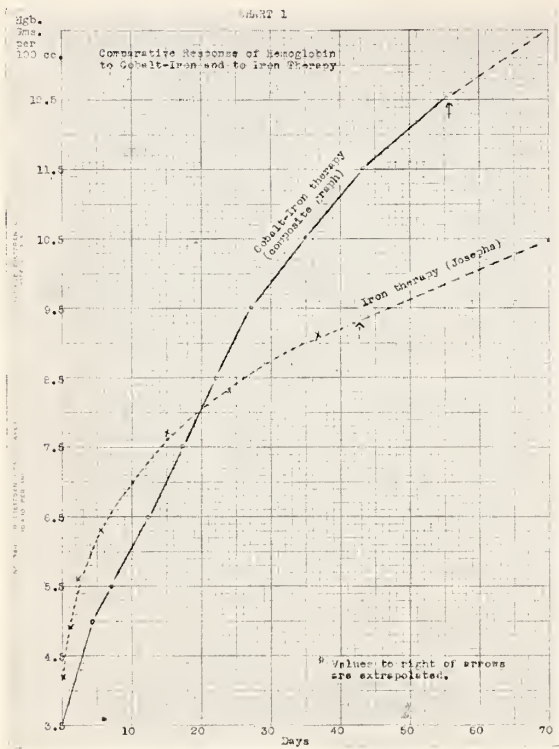


TABLE 3

Days Required for Hemoglobin to Rise Through Increment Shown with Cobalt-Iron Therapy in 16 Cases of Iron Deficiency Anemia Hemoglobin in grams:

Case	3.5-4.4	4.5-5.4	5.5-6.4	6.5-7.4	7.5-8.4	8.5-9.4	9.5-10.4	10.5-11.4	11.5-12.5
1				7	7	4			
2						4		7	
3		2	1	2	5	15			
4				10	8	8	8		
5						13	17		
6						4	8	11	10
7							10	14	25
8	3	6	8	7	8	9	8		
9				8	9	15			
11					5	9	12	11	13
12						4	4	3	
13	5	3	5	3	4	4			
14				2	4	4	7		
15				2½	4½				
16					3½	5½	5	6	7
17					4	5	5	8	
Total*	2	3	3	8	11	14	11	7	4
Av.	4.0	3.7	4.7	5.2	5.6	7.4	8.0	8.6	13.8
Mean	4.0	3.0	5.0	5.0	5.0	5.3	8.0	8.0	11.5

* Refers to total number of cases passing through this increment.

Although such a degree of utilization is not unusual for short periods during severe deficiency²⁹, the usual overall utilization from ferrous sulfate is only about 15%²². The greatly increased rate of iron utilization with cobalt-iron therapy reflects the stimulation due to cobalt, even in the less severe grades of iron deficiency where utilization is normally poor.

Discussion

We have pointed out that the evaluation of the effect of cobalt therapy in iron deficiency anemia is complicated by the hemopoietic effect of iron itself, since the latter must also be provided as a building material for hemoglobin synthesis. Clearly, the problem is one of measuring the effect of cobalt and iron administration and comparing the results with those to be expected from iron alone. Because reliable data for iron appears in the literature, we did not feel it necessary to repeat such a "control series".

In our series of cases, cobalt proved to be a powerful stimulant to erythropoiesis, with an action similar to, but much more powerful than that of iron. This stimulating action, however, appears to be self-limiting. Thus, in several of our cases, increases to erythremic levels occurred

but these gradually returned to normal values even though cobalt therapy was continued for periods up to 100 days. Iron, of course, sometimes causes a similar effect³⁰.

The erythropoietic effect of cobalt is also evidenced in other ways. About half of our patients showed a significant increase in blood platelets during cobalt therapy and 7 showed an increase in leucocytes. This is considered to be an important indication of increased erythropoietic stimulation³¹. Increased reticulocytosis is apparent with cobalt, although it is more erratic than with iron alone and does not appear to bear any direct relationship either to erythrocyte increases or to hemoglobin. The published findings that cobalt is effective in certain hemolytic anemias¹² lead us to wonder whether the effect on reticulocytosis could be one of alteration of the degree of splenic inhibition of the release mechanism, rather than one of direct erythropoietic stimulation.

With hemoglobin values below about 50%, cobalt does not appear to increase the rate of formation of hemoglobin over that which can be expected from adequate iron therapy in iron deficiency anemia. Above this level, however, cobalt seems to maintain a much more rapid rate of gain. We have interpreted this to mean

that cobalt stimulation is capable of maintaining iron utilization near the physiologic maximum even though iron alone, and the normal physiologic stimuli, become less effective as normal values are approached.

The sharp decrease in the rate of hemoglobin synthesis and the lack of effectiveness of iron compounds generally in the less severe, commonly encountered grades of iron deficiency anemia is well summarized in the work of Cass, *et al*³⁴. Using a group of 64 juvenile patients, aged 6 to 9, with beginning hemoglobin values of "75% to 80%", they found average hemoglobin increases of only 0.175 gm. per 100 cc. per week with ferrous sulfate or 0.265 gm. per week with iron sodium malate, although the dosages used provided 300 mg. of elemental iron per day.

Such values are well below the expectancy as determined by Heath and are small indeed as compared with the increases seen in our series of patients with cobalt-iron therapy.

It appears to us that iron alone would be adequate therapy for a short period in cases of severe iron deficiency, but that cobalt and iron would be much superior either as the case improves or initially in the less severe grades of iron deficiency anemia. Such a view is in sharp contrast to that of Berk, *et al*⁸ who felt that cobalt should be used only in severe cases, or in those "refractory" to iron.

It has become popular to express hematologic improvement in terms of comparison with the results of blood transfusion^{17, 32}. On the basis of 15 cc. of whole blood per kilo (approximately 1000 cc. in adults), values may rise by 1,000,000 cells per cmm.³³ and hemoglobin may increase by approximately 2 gm.³². In our series, the average cell increase per week was approximately $\frac{3}{4}$ million cells and, for initial hemoglobin values below 9.5 gm., hemoglobin increased nearly 2 gm. per week. Obviously, the administration of the cobalt-iron mixture produced approximately the same result as would the transfusion, in adults, of about 1½ pints of blood each week.

Toxicity. Cobalt is one of the group of "heavy metals", with chemical properties similar in many respects to those of iron. In fact, the electron shells of the two atoms differ only by a single electron in the M orbit. It is not surprising, therefore, that the toxicity of cobalt

does not seem to be greater than that of iron.³⁵ Practically all investigators report occasional gastro-intestinal side effects from doses of over 100 mg. of cobalt chloride per day; and frequent nausea and vomiting with doses of 300 to 500 mg. daily. As with iron, enteric coating obviates the effect to a considerable extent.¹⁷ Side effects referable to the autonomic nervous system have been reported from parenteral administration^{9, 15} but not from oral use. It appears that an occasional patient may show idiosyncrasy to the metal³⁶ as evidenced by a mild skin rash.

Some of the side effects ascribed to cobalt may be due to the presence of lead, since Stanley, *et al*³⁷ found that several commercial samples contained quantities of this impurity which rendered them unfit for medicinal use despite the fact that they purported to be pure material. Using "lead free" cobalt chloride, these authors showed that oral cobalt chloride, in rats, was without significant toxic effects in doses up to at least 40 mg. per kilo. Such doses are, of course, relatively very much larger than those used in human therapy.

The cobalt chloride used in the preparation of our cobalt-iron preparation was essentially free of lead and contained less of this impurity than the Pharmacopoeial rubric for iron and ammonium citrates. In our hands, this cobalt-iron preparation, in the dosages used, produced no toxic symptoms.

Summary

A comparison of cobalt-iron therapy with that of iron alone in the iron deficiency anemia of infants and children has been made. Although the number of cases is admittedly small, we believe the results are sufficiently clear cut to leave little doubt as to the validity of the conclusions reached.

In a general way, cobalt appears to be a powerful stimulant to erythropoiesis and to be able to maintain hemoglobin formation near the physiologic maximum. We know of no other agent which will accomplish such an effect.

It would appear that the administration of cobalt and iron together would have significant advantages over the use of iron alone in nearly all cases of iron deficiency anemia in infants and children.

In a series of cases, we observed no signs of toxicity or side effects in the doses used. It is

possible that this relative freedom from side effects was due to the absence of certain impurity from the preparation used by us.

The therapy used by us was approximately equivalent in results to the transfusion of $1\frac{1}{2}$ pints of blood weekly in adults.

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MIGRAINE—TO DATE

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MIGRAINE, commonly called "sick headache," is one of the oldest diseases or syndromes known, having been mentioned in the Sumerian account of the deluge, 3000 B.C. Though it is commonly encountered in practice it wasn't until a few years ago that migraine was included in the teaching curriculum at the University of Louisville; and although a great deal has been written on the subject, many patients are still often incapacitated by migraine. Yet, most patients receive very little sympathy.

There are many causes for and many different types of headache. For example, the head pains due to brain tumor, aneurysm or organic brain diseases vary from the headaches suffered during a migraine attack. However, we are limiting ourselves to a discussion of migraine.

Etiology

There are many causes and so-called "triggers" that can set off an attack. It is universally agreed:

- 1) that there is a hereditary factor in nearly all cases;
- 2) that women are affected more than twice as often as men;
- 3) that the intelligentsia are favored victims;
- 4) that the migrainous person is tense, temperamental, highly sensitive, and reactive;
- 5) that migrainous women are socially attractive, quick, conscientious and painstaking;
- 6) that most patients tire easily and wilt suddenly;
- 7) that easy depression is a common trait and sometimes precedes an attack;
- 8) that migraine often accompanies or results from allergic conditions.

Because of the psychosomatic factor and because the etiology may sometimes be multiple, varied

and often complicated, a minute and painstaking history is absolutely necessary.

The Attack

Between migraine attacks the patient has no symptoms; he usually feels very well and presents no organic or physical abnormality. Because there usually is no pathology a considerable evaluation is required to establish the diagnosis. Migraine is one of several types of vascular headaches. Among vascular headaches are: classical migraine, Horton's encephalalgia (akin to histamine headache), tension headache, ophthalmic headache, hypertension headache—all present a vascular element and all are controlled by vasoconstrictors. It is well established now that the sequence is classical migraine attacks is:

1. constriction of the arteries of the skull (Prodromal phase).
2. dilation pain phase.
3. swelling and stiffness of the vessel walls (the nausea stage).

Although the temporal artery is perhaps, most often involved and pain can be temporarily relieved by compressing it digitally, most intracranial arteries are believed to be involved.

During the first stage, the vasoconstriction stage, the patient has eye symptoms such as scotoma, watering of the eyes, and nasal stuffiness. The first stage is usually short followed by vasodilatation of cranial vessels, especially the branches of the external carotid, temporal and sometimes the occipital artery. The headache is caused by "vessel stretching." The pain usually is unilateral over the eyes, in the frontal and temple area and sometimes occipital. It may occur first on one side of the head and migrate to the other. The third stage is accompanied by edema and arteritis, causing nausea and vomiting. In certain individuals medication may sometimes cause increase in the nausea.

Treatment

The treatment is divided into prevention and relief of attack.

a) Prophylactic — Prophylaxis is difficult principally because of the psychosomatic factor and other factors which complicate the precipitation of an attack. It is necessary to keep the patient well nourished and have him follow a well balanced diet. Supplements of vitamins, minerals, hormones are often indicated. Habit adjustment is often advisable. Each case is a law unto itself. One should try to discover the cause of the "trigger upsets" and have the patient avoid them. This type of prophylactic program may necessitate an entire change of living as well as emotional and personality adjustments which may often be accomplished gradually through psychotherapy. Such patients are often not too willing to cooperate since it hurts their pride to be told they require psychotherapy. An explanation of the relation between their attack and their problems often helps ease the patient into cooperating for such therapeutic procedure. Hormones are very helpful in treating women, who require careful guidance through the menopause. Migraine usually stops after the climacteric. Migraine attacks also usually cease during pregnancy. This may be an indication that hormone imbalance may be the etiologic agent in some cases. A combination of Testosterone and Stilbestrol is used by some migraine specialists with success, particularly in women. Vitamins play a part in the continued successful handling of some migraine patients, for, if vitamin balance is kept up, it has been observed in these individuals that their attacks become milder. Vitamin B₁, B₁₂ and E are especially helpful between and during an attack. Food idiosyncrasies play a part and those foods to which the patient is allergic must be scrupulously avoided. Bellergal taken regularly between the attacks, in many cases, will postpone and even prevent an attack. Accompanying conditions like eye pathology, sinusitis, naso-rhinitis, obesity, high blood pressure, constipation, hypoglycemia, etc., etc., must be controlled by proper treatment. A desensitization to antihistamine i.v. has proved useful as a prophylactic measure. However, histamine drugs, though valuable in other allergic conditions, have not been found effective in preventing migraine attacks. We are still trying

them hopefully and lately believe Phenergan, 2 tablets at bedtime, has merit.

b) Symptomatic—In the relief of the specific migraine attack ergot derivatives are most effective, though DHE 45 and ergonovine parenterally are less toxic than ergotamine tartrate. If ergot constrictors do not relieve an oncoming attack when used early, the headache is probably not a vascular one. Cafergot, a new oral preparation is perhaps the most effective of these drugs yet developed. It is a combination of caffeine and ergotamine. Caffeine has been a component of headache powders and tablets for a long time, and certainly is valuable in overcoming the great depression that goes with these attacks. When taken orally, it acts as an aid in constricting the arteries. Cafergot (formerly called Cafergone) should not only be started early, but repeated often at half hour intervals if an attack is not aborted by the first dose of 2 or 3 tablets. A good way of prescribing Cafergot is to have the patient take two or three tablets and repeat one tablet every half hour until six are given, should relief not be obtained with the first dose. Once the therapist finds out the number of tablets that are needed to abort an attack, that dose can be taken at one time at the earliest signs of the next attack.

When there is a dominant gastro-intestinal involvement, Gynergen or DHE 45 may be given hypodermically, or an ergonovine tablet placed under the tongue. In severe stomach upsets, the alkaloids of hyoscyamus and belladonna may be given rectally or orally to overcome the tendency to vomit. Suppositories of Cafergot which are now being successfully used experimentally will be a great aid for those patients with gastric upsets and when no medication can be absorbed from the stomach. We must not overlook the fact that ergot preparations are all potent drugs, and should not be given in arteriosclerosis, peripheral vascular diseases, organic heart disease, hypertension, or pregnancy. No more than six tablets in one day or ten in a week should be administered.

Niacin is effective in a certain number of cases, especially in the vasoconstrictor stage. It should be given in 25 to 100 mg. doses to get flushing of the face. Most patients soon learn that an ice bag is the best local application as it relieves the pain by constricting the arteries. Quiet in a dark room is helpful also. Analgesics

are not effective for the relief of the attack *per se*, but can be employed effectively to relieve residual pain. Of the analgesics, aspirin is probably the best (it raises patient's tolerance of pain), the most popular combination being aspirin combined with acetophenetidin and caffeine citrate, or if given at night a barbiturate should replace the caffeine. The barbitol preparation and the belladonna group of alkaloids are all valuable therapeutic adjuvants for the relief of tension and spasm. Potassium thiocyanate has been used with some success in cases where

there is tendency of increased blood pressure. All morphine and derivatives are absolutely contraindicated for though effective, they are habit forming. Edrisal containing analgesics with amphetamine instead of caffeine is effective in some instances. Ephedrine is vasoconstricting and can be used intranasally as well, to shrink blocked nasal passages. Histamine desensitization, oxygen inhalation, Octin, Trichlorethylene inhalation and other agents have been used with varying degrees of success, but, in my hands, have proved of little value.

HYSTERECTOMY—A CLINICAL CONSIDERATION

Tulane University practice has swung steadily away from supravaginal hysterectomy with improved mortality rate and avoidance of complications seen when the cervix is left in. During one period total hysterectomy showed a mortality of 1.3% in contrast to 2.75% mortality following supravaginal hysterectomy. Cancer of cervix was found by the pathologist in several patients who had had recent normal cervical biopsy.

The author feels either the abdominal or vaginal route may be used and that any surgeon should be able to elect the better procedure for a particular patient. He feels that any patient adequately prepared for a supravaginal hysterectomy can survive the total operation.

In the last 2½ years at Tulane only 0.39% of hysterectomies have been of supravaginal type contrasted with 40% in 1942.

C. Gordon Johnson, M.D., J. Kansas Med. Soc. 54: 413. Sept., 1953.

OBSTRUCTIVE LESIONS OF THE URINARY TRACT IN CHILDREN

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OBSTRUCTIVE LESIONS of the urinary tract in children are extremely dangerous conditions because their presence is often overlooked by both parents and physician until permanent damage to one or both kidneys has occurred. When early diagnosis is made surgical relief of the obstruction can be performed with excellent, and often lifesaving, results. Recurrent or persistent urinary infections consisting of either cystitis or pyelonephritis are the main danger signals that an obstructive lesion may be present. *More than one urinary infection in a child demands urological investigation, if this has not already been done.*

Lower urinary tract obstructions from the bladder to the urethral meatus will produce signs and symptoms of pain, difficulty, frequency, incontinence, or presence of a mass in the supra pubic area due to the enlarged bladder. When infection supervenes dysuria, strangury, pus or blood in the urine also occur. Late complications are dilatation of the bladder and bilateral hydroureter and hydronephrosis with irreparable kidney damage. The irreparable renal damage is due, both to ischemia caused by pressure from the hydronephrosis, and also to the establishment of a chronic pyelonephritis which is refractory to all treatment.

In the routine examination of the well child much can be done to discover these conditions. A few simple questions should be directed at either mother or child as to:

1. pain, sharp, or dull, in either flank or upper abdomen,
2. frequency of urination,
3. pain, difficulty, or crying when urinating,
4. pus or blood in the urine,
5. unexplained fever.

On physical examination of the child only a

few seconds need be taken to look for phimosis, a pin point meatus, abdominal tenderness, or a palpable bladder or kidney.

If obstruction is suspected complete early diagnosis and treatment is imperative. A residual urine determination will almost always establish the diagnosis of lower tract obstruction, although minor degrees of obstruction may exist with no residual urine. This is a test too often omitted by the busy practitioner.

The most common site of lower tract obstruction is a stenosis of the urethral meatus. This is a very easily overlooked condition and can cause great difficulty.

Congenital strictures of the urethra, valves in the prostatic urethra, and bladder neck contracture are the next most commonly occurring causes of lower urinary tract obstructions.

Phimosis with a pin point orifice in the foreskin so that on urination the foreskin blows up like a balloon is another cause of obstruction.

Neurogenic difficulties, as from a spina bifida, produce much the same symptoms and results as true obstructive lesions.

There are many other rare causes of lower tract obstruction unnecessary to keep in mind such as an enlarged veru montanum, urethral stone, prostatic hypertrophy or malignancy, etc.

Obstructions in the ureter or renal pelvis are usually unilateral and, while serious, do not threaten life as do the lower tract obstructions which affect both kidneys. The most common of these obstructive lesions are strictures, most frequently occurring at each end of the ureter. The ultimate result is a hydronephrosis and renal atrophy with infection or stone often occurring.

The presenting symptoms may be those of an acute pyelonephritis, a dull or sharp pain in the flank, vague abdominal pain, unexplained

fever, failure to gain weight, or the lesion may be completely asymptomatic.

When the diagnosis is made early and irreparable damage from hydronephrosis or pyelonephritis has not occurred, definitive surgical treatment can save the involved kidney. Very frequently, however, nephrectomy is necessary simply because there was too much delay in arriving at a diagnosis.

The usual presenting symptom of any urinary tract obstruction in a child is urinary tract infection. It is far too easy for the hurried family doctor to treat the infection empirically with antibiotics and not attempt to discover why the infection developed. The pus is cleared temporarily from the urine, and the fever and pain subside only to recur some time after suspension of treatment. This should point to the need for urological investigation, if nothing previous has done so.

I would like to report a few personal cases to emphasize some of the points I have made.

Case Reports

1. R. B. was an 11 year old boy when first seen. At the age of 5 his mother finally took him to a doctor because his lower abdomen had protruded for several years. He also had had frequent difficult urination which had not concerned her. Urological investigation upon referral disclosed that the abdominal enlargement was due to a hugely distended bladder. A lower urinary tract obstruction was present in the form of prostatic valves. Bilateral hydroureter and chronically infected hydronephrosis was present. The valves were destroyed by electrocoagulation and the boy was able to empty the bladder well. However, irreversible changes had occurred in the upper urinary tract and over a period of 6 years renal function declined. When the boy came under my observation, severe bilateral hydroureter and hydronephrosis were present, renal function was very poor, and both kidneys were infected. On voiding ureteral reflux would occur due to the enormous dilatation of the ureters. A supra-pubic cystostomy was done in order to eliminate the ureteral reflux and avoid any further insult to the badly damaged kidneys. In spite of this and intensive antibiotic therapy, renal function gradually declined and he died in uremia one year later at the age of 12.

If this case had been investigated early, at the first signs and symptoms, or if an examining doctor had palpated the enlarged bladder, this child's life might have been saved. The obstructive lesion was an easily correctible one, but in this case irreversible and progressive changes had taken place in the kidneys by the time of definitive treatment.

2. R.F., a 4 year old boy, had had repeated urinary tract infections since the age of 6 months. He had actually been in a large hospital for treatment of one infection more severe than usual.

Examination disclosed a pin point meatus and a right undescended testis. Meatotomy was done immediately and a catheter passed to the bladder seemed to block at the vesical neck.

An intravenous pyelogram disclosed a normal right kidney with non-visualization of the left kidney. The residual urine was 250cc. A cystogram showed a large bladder with the upper half ballooned out atonically. Cystoscopy confirmed the impression of vesical neck contraction. An impassable stricture of the left ureteral orifice was present.

Because of the large atonic upper segment of the bladder I decided to do a supra pubic resection of the bladder neck and at the same time resect the atonic bladder segment which actually amounted to a large diverticulum. Investigation of the left ureter could also be carried out. This was performed as planned, and exploration of the left ureter confirmed the pressure of a lengthy lower ureteral stricture with an enormously dilated ureter above. As the kidney could not be investigated through the supra pubic incision, the ureter was transected above the stricture and reanastomosed to the bladder. The post-operative course was uneventful and following removal of all drainage tubes the boy could completely empty his bladder. Cystoscopy, left retrograde pyelograms, and differential function studies showed the new left ureteral orifice to be open widely and the left kidney to be atrophic and functionless. Urine was excreted but was little more than water. As no infection was present in the left kidney at this time and all obstruction had been removed, an attitude of watchful expectancy was adopted. If trouble developed left nephrectomy could be performed anytime. When last seen about one year after surgery, the boy was voiding easily and had no

residual urine. There had been no symptoms referable to the left kidney. Fortunately, the vesical neck obstruction was corrected before back pressure effects damaged the good right kidney.

3. J.F. was a seven year old girl who when first seen was thought to be a behavior problem. Because of the presence of albumin and a few pus cells a blood urea nitrogen was obtained which proved to be 60 mgs.%. A diagnosis of glomerulonephritis was made and the child was treated accordingly. A urological consultation was finally obtained, mainly at our urging. A residual urine of about 6 ozs. was present. Cystoscopy showed a contracted vesical neck and retrograde pyelograms disclosed a bilateral hydronephrosis. Catheter drainage was instituted immediately. In a week the blood urea nitrogen fell to normal and the behavior problem disappeared entirely. Transurethral resection of the vesical neck was then done. The post-operative course was uneventful and the child left the hospital voiding easily with no residual. However, I am sure that irreversible changes had been established in both kidneys. She will probably die before reaching the age of 21 as a result of renal failure from a progressive chronic pyelonephritis refractory to all antibiotics.

Here is a child who to all intents and purposes had a chronic nephritis. As there is no curative treatment for this progressive condition, urological workup was definitely called for in the hope of finding a surgically correctable condition.

4. J. H. was a 7 year old girl who had had many attacks of unexplained fever and abdominal pain over a period of years. Finally, one physician finding pus in the urine referred her for urological workup. Investigation disclosed a left infected hydronephrosis due to a mild ureterovesical stricture. Function was decreased and the kidney was so badly damaged that nephrectomy was decided upon. This was carried out and the mother now reports the child is healthy and has become much happier and pleasant. It is possible that her left kidney could have been saved if the diagnosis had been made several years previously.

5. D. S. was a 7 year old girl who had had three attacks of urinary infection with gross hematuria and mid-abdominal pain in the pre-

ceding year. Her infections had been treated empirically with no urologic investigation being performed. Intravenous and retrograde pyelography disclosed a horseshoe kidney with no evidence of renal disease. In this type of renal anomaly the ureters descend anterior to the isthmus connecting the two lower poles. There was no definite obstruction of either renal pelvis as shown by x-ray, yet it was felt that because of the three attacks of kidney infection in the preceding year obstruction of one or both of the ureters by the connecting isthmus must be assumed to be present. Rather than wait until definite pyelographic evidence of obstruction occurred with inevitable renal damage, active surgical relief of the obstruction was decided upon.

Through a right lumbar retro-peritoneal approach the isthmus was divided and nephropexy of the right segment was carried out. By this maneuver it was hoped to remove the pressure on the right ureter thereby eliminating the tendency to infection of the right kidney. The child will be followed carefully and if further infection develops in the left kidney nephropexy will be performed on that side. It is yet too early to predict the outcome of this case.

6. V. R. was also a 7 year old girl with a long history of right flank pain, enuresis, and pyuria. Urologic investigation disclosed a congenital stricture of the urethra. The bladder and upper urinary tract were essentially normal. The stricture was dilated and a 16F Foley catheter was left indwelling for a period of ten days. Following removal of the catheter the child voided well. There has been no recurrence of the right flank pain, enuresis, or pyuria to date.

Summary

The necessity for early diagnosis of obstructive lesions of the urinary tract in children has been stressed. The practice of treating every urinary infection in children empirically with antibiotics with no attempt being made to determine the cause of the infection is to be condemned. Several illustrative cases were reported.

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HOUSE OF DELEGATES

THE ACTIONS of the House of Delegates are reported in this issue of THE JOURNAL in a new and simplified form.

The old way was to record each session of the House separately. This placed the account of all the resolutions in one section of the proceedings, and the action on the resolutions in another section.

Attention is called to the new method of reporting the proceedings, wherein the action is set out immediately following each resolution. This consolidated system combines the two sessions to provide a more understandable and easily read account of all the decisions of the House of Delegates.

TEAMWORK MADE CONVENTION OUTSTANDING

THE 1953 STATE CONVENTION was a splendid meeting—one of the largest registrations at French Lick—biggest and best technical exhibit—well attended scientific sessions—plenty of red hot politics. It was also a smoothly conducted convention, one of the best from the standpoint of arrangements and administration that the association has ever had.

Battles are won by having the right people

and the right things in the right place at the right time. Conventions are made to function smoothly on the same formula. Few people except those behind the scenes have any idea of the vast number of details and the high degree of coordination which are necessary for a well conducted meeting such as ours.

Jim Waggener, as general manager of the convention, deserves high praise for his handling

of the details and for the coordination which made the meeting so efficient.

The hotel management cooperated in every way possible and contributed to the comfort and entertainment of all the registrants. All the officers of the association and the entire headquarters staff worked together to accomplish a marvelous result. Jim was the man who remembered all the minutiae and coordinated the big show.

His instructions to the hotel, covering all the individual meetings down to the smallest com-

mittee and smallest item, were complimented by the management as the best they had ever received. In addition to this voluminous document, each member of the staff was furnished with a complete listing of duties and responsibilities for the entire four days.

The association owes thanks to the Orange County Medical Society and the Vanderburgh County Medical Society, co-hosts for the convention, to the technical exhibitors, to all the participants in the scientific program, and especially to Jim Waggener and his staff for their outstanding job of convention management.

MEDICAL CIVIL DEFENSE IN A NON-TARGET COUNTY

AT THE GOVERNOR'S Civil Defense Conference on October 25 a report was given concerning a non-target county's medical civil defense plan which may well serve as a model.

It is generally recognized that most of the rescue and medical care for an atomic bomb target must come from outside the target area. The disrupting and shocking power of a tremendous explosion is sufficient to numb the faculties of the survivors. They must depend on outside help, at least in the early stages of recovery.

Because of this all counties in Indiana should be organized for mutual support. A few counties are likely targets for atomic bombing. A few more are unlikely but possible targets. These counties should be organized for their own protection and for mutual aid to each other.

Still other counties are such unlikely targets as to enable them to plan almost exclusively for

service to their neighbors in event of a major catastrophe. Such a county is Tipton County, the subject of the above mentioned report.

It is heartening to find out what Tipton County has been able to do toward an effective and workable disaster plan. The plan will not only serve its primary purpose of rendering aid to adjoining communities in the state, but also will be of great assistance to Tipton County for local emergencies.

It is interesting to note that their plan has not been expensive, it has not cost much money. It has received a large expenditure in sound thinking, in careful organizational work and in public spirited cooperation, all attributes which the citizens apparently have in plenty, but it has not been an expensive program financially.

It is a program which any community may emulate, regardless of the shriveling effect of small appropriations or the complete lack of appropriations.

ACCOMPLISHMENT

TO OUR NOTION, the French Lick meeting demonstrated, if nothing else, that physicians—real practicing physicians—can still settle their own affairs, and do a darn good job of it, too. It further showed that our system of organization, described occasionally by some as fusty, nevertheless is capable of carrying us through rough waters on a remarkably even keel.

All this by way of paying our respects to those

reference committees which were under some pretty severe fire, but who kept their heads and came up with solutions which did not beg the question yet which maintained the dignity of the state association while showing just a glimmer of iron fist through the velvet glove. It is to be hoped that the rank and file of our membership will read the minutes of this session, when published, the better to appreciate the efforts of their delegates in convention assembled.

President's Page

FELLOW MEMBERS OF I.S.M.A.

December, 1953

WHAT priority do we give health care? Failure to meet health needs may not be due so much to the lack of "ability" to pay as to the low priority which many individuals put on expenditures for health.

We do not hesitate to go in debt for a TV set or an automobile and mortgage our income for months ahead—but hesitate to go into debt for an operation or adequate medical care. Is a TV set more important than good health? Indeed with all the insurance programs available borrowing is not even the alternative.

Why do we respond so readily to the urge for another cigarette, or cigar, another beer or whiskey and soda? Yet, an ache or pain, or even a persistent lethargic feeling, fails for the most part to stimulate us to consult competent medical counsel. Why, according to one recent dental survey, did 90% of the children need dental care?

Is it due primarily to lack of ability to pay, or, is there some deep seated reason?

Many an individual believes that his body requires little maintenance and that it will stand a lot of punishment. He feels that a few patent medicines are all he needs, or that there is no use going to the doctor until he can get his money's worth.

All of us would rather spend money for something that will bring immediate gratification rather than for medical care.

In 1951 consumers expenditures for health services came to \$8,976,000,000 as against almost as large a figure, \$8,450,000,000, for alcoholic expenditures. Consumers spent 50 cents on smoking supplies for every dollar spent on health and medical services.

The average spent for health care the country over is \$4.00 to \$5.00 per \$100.00 of income.

All this does not imply that nothing else is needed. The indigent must be considered and there is need for additional public health work in many areas.

Our economy can provide adequate health care in the same sense it can provide automobiles, kitchen facilities or anything else that has a high enough priority with the average citizen.

The public has shown its willingness to pay the increasing amounts for hospital care, but a point can be reached where the cost of hospital care exceeds what they are willing to pay, and consequently might prefer to spend the excess amount in some other way.

Similarly, in the field of medical services who can say definitely what services should be extended and which diminished?

Indeed we are dealing with values—the problem of values in a free society.

Wm Harry Howard M.D.

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

HOSPITALS . . . AND CHISELING

The speech that Dr. Paul D. Crimm of Evansville prepared—but did not deliver—for his “farewell address” as president of the Indiana Medical Association this week was full of good solid courageous plain talk.

He does plan to publish the speech, and we hope he will, because what he had to say is worthy of more attention than we’re afraid it’s going to get.

Especially what he had to say about hospital care for war veterans.

We knew an Indianapolis man, now deceased, who spent the last full year of his life as a patient in a veterans hospital at not one penny of cost to himself. He owned a prosperous small business, had an income we’d estimate at \$10,000 or \$12,000 a year, and no dependents. He had served in uniform something less than 60 days in a training camp in the First World War. That’s duplicated—literally thousands of times.

Nearly anyone can point to a similar case within his own circle of acquaintances. The fact is that anyone who served even a day or so in uniform 35 years ago can get the same kind of “free” medical and hospital care, by merely making an unsworn statement that he “can’t afford” to pay for it.

There are now, in the United States, more than 15 million men and a few women, whose medical care is guaranteed for as long as they shall live because they once wore their country’s uniform in war time.

* * *

* * *

We do not refer to the men who were wounded, or who came out of service otherwise physically or mentally incapacitated as a result of that service. No one questions their claim to the best medical care.

We do mean the fellow who came down with some ailment years later that he’d have had whether or not he ever put on a uniform and who still moves in for free treatment.

He gets the treatment—not only at the public expense, but also at the expense of the man who is really entitled to it. Every dollar spent on hospital care for one of those chiselers is a dollar that can’t be used to help some man who lost his eyes or his legs in battle. There isn’t even any way of learning how much of the enormous cost of vet-

erans hospital operation is incurred by such cases, but there is reason to believe it is much more than half the total. As the younger World War II veterans approach middle age a few years from now, and begin to require more medical care, that will go up and up and up.

The system is purely political. It exists, against the better judgment of those in charge of it, because veterans organizations are feared pressure groups—and they have been far too enthusiastic in their grab at the public treasury. The cure lies, most readily, with those organizations themselves. If they’d take off the pressure this whole business would soon get back to a common-sense basis. If they don’t, they will ultimately endanger the whole program for proper care of the veterans who really are entitled to it.

—*The Indianapolis Times*

Conference on Scientific Editorial Problems Set

An open conference on Scientific Editorial Problems has been scheduled for December 27 in Boston during the annual meeting of the American Association for the Advancement of Science.

Many important problems which confront those who prepare scientific manuscripts and technical reports or who edit and produce scientific publications will be discussed. Outstanding speakers will include W. Albert Noyes, Jr., editor of *Journal of the American Chemical Society*; Milton O. Lee, managing editor of *American Journal of Physiology*; and Joseph D. Elder, science editor of *Harvard University Press*.

Dr. L. E. Burney, director of the Indiana State Board of Health, was presented the Good Government award of the Indiana Junior Chamber of Commerce recently. He was cited as the individual in the state who made the greatest contribution toward improving government service during the past year.

(The Council on Pharmacy and Chemistry of the American Medical Association has adopted the following statement which appears in *New and Nonofficial Remedies*, 1953, Philadelphia, J. B. Lippincott Company, pp. 171-173, 1953.)

METHANTHELINE BROMIDE.—*Banthine Bromide (Searle)*

β -Diethylmethylaminoethyl 9-xanthenecarboxylate bromide

Actions and Uses.—Methantheline bromide, a parasympatholytic agent, produces the peripheral action of anticholinergic drugs such as atropine and the ganglionic blocking action of drugs such as tetraethylammonium chloride. Tolerated amounts of methantheline bromide exert side effects typical of atropine-like drugs, but cause less tachycardia, and also cause less postural hypotension than does tetraethylammonium chloride. Toxic doses produce a curare-like action at the somatic neuromuscular junction.

Clinical studies indicate that the drug effectively inhibits motility of the gastro-intestinal and genito-urinary tracts and, to a variable degree, diminishes the volume of perspiration and salivary, gastric, and pancreatic secretions. It also decreases mucoprotein secretion. Like atropine, it produces mydriasis and cycloplegia when applied locally to the eye or administered systemically, but until more clinical evidence becomes available, its local use for this purpose is not recommended. The value of the drug for preventing abnormal cardiac reflexes through the vagus during thoracic surgery, or as an agent for routine preoperative medication in place of atropine, requires further investigation before final conclusions can be reached.

Methantheline bromide is indicated for clinical use whenever anticholinergic spasmolytic action is desired, provided it is not contraindicated because of its atropine-like characteristics or because of a patient's intolerance to the unavoidable side effects of such therapy. It is useful as an adjunct in the management of peptic ulcer, chronic hypertrophic gastritis, certain less specific forms of gastritis, pylorospasm, hyperemesis gravidarum, biliary dyskinesia, acute and chronic pancreatitis, hypermotility of the small intestine not associated with organic change, ileostomies, spastic colon (mucous colitis, irritable bowel), diverticulitis, ureteral and urinary bladder spasm, hyperhidrosis or control of normal sweating which aggravates certain dermatoses, and control of salivation.

Methantheline bromide produces some degree of cycloplegia and mydriasis in therapeutic doses and

therefore should not be administered to patients with glaucoma. It sometimes decreases the ability to read fine print. Xerostomia (dryness of the mouth) is a common, sometimes transient, side effect. Urinary retention of varying degrees may occur in elderly male patients with prostatic hypertrophy, and some patients may have difficulty emptying the rectum. Patients with edematous duodenal ulceration may experience nausea and vomiting during initial administration of the drug. These patients should take only liquids during the institution of drug therapy. All patients should be advised of the possible occurrence of side effects. Overdosage sufficient to produce a curare-like action may be counteracted by prompt subcutaneous injection of 2 mg. of neostigmine methylsulfate.

Dosage.—Methantheline bromide is administered orally or parenterally by either the intramuscular or intravenous route. Parenteral administration is not advised for patients able to take the drug orally. The average initial dose for adults, oral or parenteral, is 50 mg. For patients with considerable intolerance, 25 mg. may be employed. In the management of peptic ulcer, a beginning schedule of 50 mg. three times daily before meals, and 100 to 150 mg. on retiring is suggested. However, the usual effective dose is 100 mg. four times daily, although some patients may require more or less than this amount. The dosage may be increased to tolerance, using dryness of the mouth as a guide, and adjusted to meet the individual response of patients. Maintenance dosage in peptic ulcer is usually considered to be about one-half the therapeutic level. In the management of other hypermotile or hypersecretory states, the dosage should be adjusted to the smallest amount which will relieve the symptoms. When spastic conditions are secondary to inflammatory or other organic lesions, therapy directed toward the cause should be employed whenever possible.

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Powder Banthine Bromide: 2 cc. ampuls. 50 mg.

Tablets Banthine Bromide: 50 mg.

HEALTH SERVICES EMERGENCY PLANS OUTLINED AT CIVIL DEFENSE MEETING

DURING the two-day Governor's Civil Defense Conference held on October 24 and 25 in Indianapolis preparations for care of the injured in target and non-target areas were outlined by Dr. E. Vernon Hahn, Health Services Director of the Marion County Civil Defense, and Dr. Jean V. Carter, who fills a similar post in Tipton county.

Meetings of the Health Services section were held in Rice Auditorium, Indiana State Board of Health. Following opening remarks by Dr. L. E. Burney, director, Health Services Division, Indiana Department of Civil Defense, and discussion of the status of the program in Indiana by Robert Rogers, a forum was held. "Operation of the Health Services Post Disaster Program" was discussed by Dr. Louis W. Spolyar, T. E. Sullivan, Dr. Martha O'Malley, Dr. Glen Ward Lee and Dr. Clyde G. Culbertson.

Dr. Hahn, in telling of preparation in a target county, outlined the simplified treatment plan, medical treatment stations, evacuation of casualties and zoning of the county.

Dr. Carter's report on preparation in a small non-target county is given here in full. Tipton county's full-scale Civil Defense program plans follow:

Tipton County is small, located about 40 miles from the major target area of Indianapolis and about the same distance from minor target area of Anderson. We have 11 active doctors in the county.

When we first began on Civil Defense, meetings were held with the Tipton County Medical Society and the Auxiliary to study the situation. These meetings were open to the public and we usually had a film or a speaker. The best meeting was one at which Dr. Ward Lee was speaker. It was from him that we learned we were expected to set up five times as many temporary beds as we had beds in the hospital of Tipton County in case of emergency.

We had already set up our Advisory Council and now with a definite goal, we set about to work toward it. Rough surveys were made of

school houses in the City of Tipton—buildings were selected with gymnasium floors, toilet facilities and kitchens on ground floor. We estimated that an ordinary gymnasium floor, plus two or three smaller rooms for more serious cases, would carry 100 patients. Four buildings were selected—three to carry 100 patients—one to carry 50.

Next, there was the problem of getting the beds, sheets, other supplies, necessary to set up. Since storage facilities in the buildings could not be obtained, we figured 350 families should have on hand, ready for immediate use, all the things necessary for one bed. A list of things needed was completed and mailed to selected families in Tipton. This list is to be kept in the family Bible so that it can be found readily for reference and in case of emergencies, the materials put on front porch to be hauled to temporary hospitals by our trucks. The response was very good—159 people indicated they would have all of the material immediately available. Many others indicated they could easily have everything available except the cot. We then learned that the Pioneer Corn Company, Inc., and the Stokely-Van Camp Canning Company would have, for immediate loan, enough cots to make up the deficit.

Instruments, medicines, dressings, et cetera, was the next problem. About this time an offer was made whereby if one unit of Civil Defense supplies was ordered, a second unit would be given the county. We immediately put the proposition before the County Commissioners and later, the County Council. They appropriated \$1,200.00 to purchase these supplies and necessary litters when they were available. They also furnished a room in the basement of the Court House where these supplies could be stored under lock and key. Various sororities and other similar organizations were asked to bring to the county nurses' office, old underwear, old sheets, et cetera. These are being cut, put in cans, sterilized at the hospital and put in storage.

The last and biggest problem is one of personnel. This is built around the staff of the

Tipton County Memorial Hospital. The Chief of Staff is in charge of hospitals as far as medical and surgical services are concerned. It is up to him to assign doctors to various temporary hospitals in time of need. The permanent hospital has agreed to clear out as many boarders as possible in time of emergency to make way for cases of serious nature or cases needing immediate surgery. We figured other personnel on a 50-bed unit basis as follows:

Administrator—1

Clerks—4 (3 day shift—1 night shift)

Lab Technician—1 on day shift

Maintenance Men—3 (1 on each shift)

Laundry and Housekeeping—8 on day shift

Dietary—10 on 2 shifts—one (6 people) from 6 a.m. to 12:00 noon for 2 meals—1:00 p.m. until 8:00 p.m. for supper meal (4 people)

Graduate Nurses—4 at minimum—2 day shift, 1 each other shift

Nurse Aides—34 to be on basis of approximately 1 Nurse Aide to 6 patients 7:00 a.m. to 3:00 p.m.; 1 Nurse Aide to 15 patients 3:00 p.m. to 11:00 p.m.; 1 Nurse Aide to 20 patients 11:00 p.m. to 7:00 a.m. shift

Litter bearers—12 men

Communication men—4.

More than enough retired registered nurses to staff the 350 emergency beds have volunteered. All other personnel for the temporary hospitals, except nurses aides, have volunteered. We are now conducting a training program to make up the deficit.

It was assumed that not too much training would be necessary for the personnel of a temporary hospital unit except the training of Nurse Aides. We have concentrated on this training during the last year and have found it tedious and time consuming. Under the direction of Miss Welch, R.N., classes of 12 to 14 women undergo training and instruction for a 2-hour period weekly for 7 weeks, using "Medical Aspects of Civil Defense" articles reprinted from A.M.A. Journal. A doctor talks for around fifteen minutes each period about the kind of cases to be expected and what to do to care for them. These classes are to be continued during winter months starting soon and we hope by another year to have enough Nurse Aides trained. In the meantime, we continue to try to complete other projects already mentioned to accomplish our goal.

In conclusion, I wish to acknowledge the fact that what little we have accomplished in Tipton County in Civil Defense has been due to whole-hearted cooperation of Miss Welch, R.N., and the Deputy Director, Miss Jean Nash.

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Association officers in top picture wear string ties (special oxford models) in deference to President Paul D. Crimm, connoisseur of le petit cravate.

Four center photos are random group shots of doctors, exhibitors and their families in the famous French Lick Springs Hotel dining room.

Below, Joe, familiar room service waiter, leads the entire staff of waiters around the room, with flaming dessert balanced precariously on his head.



Convention Highlights...

Dr. Wm. Harry Howard, Hammond, preparing to make his acceptance speech after receiving the gavel from the retiring president of I.S.M.A., Paul D. Crimm.

Officers of I.S.M.A., special guests and Auxiliary officers at the speakers table at the annual Auxiliary luncheon.

Left center, Dr. John Scedder, Edwardsport, accepts the "Physician of the Year" plaque from Dr. Crimm.

Right center, President-elect Walter L. Porttens, Franklin, and President Wm. Harry Howard, Hammond, during a moment of relaxation from their busy convention schedules.

Fifty Year Club members and their families gather for a reception and are greeted by Dr. H. G. Weiss, Evansville, chairman of arrangements for this important annual event.



EDWARDSPORT GP AWARDED PLAQUE AS INDIANA "PHYSICIAN OF THE YEAR"

HIS SERVICE to three generations of northern Knox County residents over a period of 47 years brought recognition to Dr. John A. Scudder of Edwardsport during the recent 104th annual convention of the Indiana State Medical



Dr. Scudder

Association. On nomination of the Knox County Medical Society Doctor Scudder was named Indiana's "Physician of the Year" and was presented with a bronze plaque mounted on a walnut shield.

Doctor Scudder, a native of Knox county, received his medical degree from the old Indiana Medical College, School of Medicine of Purdue University, Indianapolis, in 1906 and immediately began practice in Edwardsport. Now 71, he recalls the early days when he made

house calls by horse and buggy or, in particularly bad weather, on horseback. Although Edwardsport is built on a hill, a call at a home in the bottomlands sometimes required a switch from horseback to a boat, he says.

The only doctor northeast of Bicknell, Doctor Scudder covers an area of about 15 miles radius around Edwardsport, his county society secretary Dr. William Keezer, said in making the written nomination.

Doctor Keezer added: "Throughout the years he has kept himself informed on new drugs and new methods of treatment and regularly attends all county and state meetings."

The annual award of the state association was made by Dr. Paul D. Crimm, retiring president, at the closing session of the 1953 convention at French Lick.

On the following Sunday, a public reception honoring Doctor Scudder was held in Edwardsport American Legion hall with the Legion Auxiliary sponsoring the affair.

Social Security Extension. HR 6812 would extend social security coverage to about 10.5 million persons, 6.5 million of whom would be brought into the system by mandatory action. The following self-employed would be required to participate, if they earn \$400 or more a year:

Physicians and interns (but not student nurses), dentists, osteopaths, veterinarians, chiropractors, naturopaths, optometrists, Christian Science practitioners, funeral directors, professional engineers, lawyers, architects, accountants, and other professional people and farmers. Mandatory coverage also is provided for farm workers and domestics earning \$50 or more per calendar quarter from one employer.

Several other segments totalling about 4 million would be offered coverage on a voluntary group basis, but would not be required to participate. Principal groups included in this category are state and local government employees now enrolled in retirement systems and ministers of the gospel. The present law giving non-contributory wage credits of \$160 a month to members of the armed forces would be continued to July 1, 1955.

If this legislation is passed, virtually the only persons not covered or eligible for coverage would be federal government employees and railroad employees. Their situations are under study by official government advisory groups.

Mr. Reed, introducing this bill at the request of the Eisenhower administration, said his action was not to be interpreted as indorsement of the plan. He suggested that it might be amended in line with recommendations of a Ways and Means subcommittee which is currently considering all phases of social security. The American Medical Association is on record as opposing extension of social security to physicians. Also opposing the principles of this legislation are American Dental Association, American Bar Association and a number of other professional organizations. AMA proposes instead that self-employed persons be permitted to defer income tax payments on a portion of their earnings which would be paid into restricted annuity plans.

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PORTER COUNTY MEDICAL SOCIETY SPONSORS COUNTY-WIDE SCIENCE FAIR



Front row, seated, left to right: Ralph C. Eades, M.D., president Porter County Medical Society; Elmer Dunbar, principal, Chesterton High School; George Bohlen (1st place winner); Tom Jones (3rd place); Norman Crowell (2nd place); Robert McCord, instructor; Thomas Hall, M.D.; P.C.F. Vietzke, M.D. Second row, standing, left to right: T. Makovsky, M.D.; J. R. Frank, M.D.; Carl Davis, chief of staff, Porter Memorial Hospital; W. C. Robertson, M.D.; H. E. Ashmore, M. D., secretary, Porter County Medical Society; J. P. Griffin, M.D.; J. W. Dale, M.D.; Charles B. Nash, M.D.; J. C. Brown, M.D.; Eugene DeGrazia, M. D.; Joseph Gordon, M.D.; C. M. Harless, M.D.; G. R. Douglas, M.D. Members of society not present for picture: T. L. Dittmer, M.D.; Jack E. Dittmer, M.D.; E. H. Miller, M.D.; A. J. VanWinkle, M. D.; C. E. DeWitt, M.D. and F. J. Kleinman.

THE PORTER COUNTY MEDICAL SOCIETY has introduced a venture in science which may well become a pet project of county societies all over the United States. The support of Science Fairs, while usually assumed by colleges and universities, was taken over by the Porter County doctors due to the initiative and enterprise of Instructor Robert McCord and his principal, Elmer Dunbar of the Chesterton High School. It was the third fair for their school, but the first county-wide contest. By supporting the event financially the medical society made it possible for the county winners to get a trip to the National Science Fair at Oak Ridge, Tennessee.

George Bohlin of Chesterton High School did the research which produced a hydrogen peroxide generator. His entry was awarded first

prize in the county Science Fair. Second place was taken by Norman Crowell who exhibited an apparatus which he had made for the transmission of sound by light. Originally only two awards were planned but the contest was so close that a third place was given to Tom Johnson, for a photo-electric apparatus for stress analysis. Each student designed and made the mechanical parts of each of the machines.

The boys were honored guests, together with their instructor and principal, of the Porter County Medical Society at its regular meeting on April 28. The three winners set up their devices in the laboratory of Porter Memorial Hospital for demonstration to the society. Later, on May 7, the three Porter County winners attended the National Science Fair at Oak Ridge, with Instructor McCord.

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¹Evans, R. R., and Rackemann, F. M.: *A.M.A. Arch. Int. Med.* 90:96-127, July 1952.

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Competitive Tests for Medical Officers Scheduled

A competitive examination for appointment of medical officers to the Regular Corps of the United States Public Health Service will be held on February 2, 3 and 4, 1954 at a number of points located as centrally as possible in relation to the homes of candidates. Applications must be received by December 24, 1953.

Application forms and additional information may be obtained by writing to the Chief, Division of Commissioned Officers, Public Health Service, Department of Health, Education and Welfare, Washington 25, D.C.

Copies of the widely discussed booklet, "Should Your Child Be a Doctor?" by Walter C. Alvarez, M.D., emeritus consultant in medicine at the Mayo Clinic, may be obtained without charge from the Public Relations Department, New York Life Insurance Company, 51 Madison Avenue, New York 10, New York.

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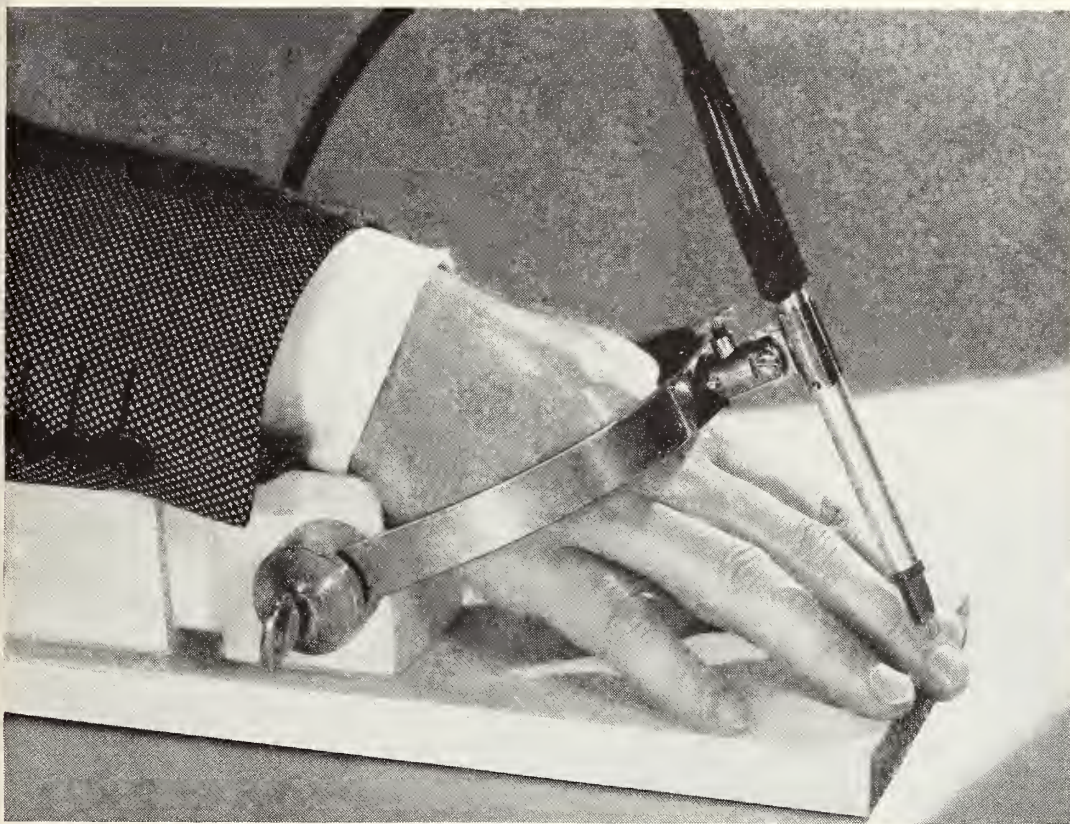
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If you have yet to try the new KENT, may we suggest you do so soon?

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School, Community Health Groups Report Activities

"Our School Health Program" was the subject of a panel discussion at a meeting of Vanderburg Advisory Health Council November 4 in Evansville College cafeteria.

Grant county found only two cases of ring-worm after examining 6,581 students in the 26 county schools. Both cases were in the same family. Woods lamp tests were employed, health authorities report.

Dr. Herbert Koepp Baker, professor of clinical speech pathology in the School of Medicine at the University of Illinois, was the principal speaker at the Northwest Area School Health Conference held at Valparaiso University on October 31. He discussed "The Variant Child."

A county-wide free chest clinic was sponsored by the Pulaski County Health Association on October 28 in the Winamac court house. Dr. Warren Tucker, Indianapolis, made the examinations.

The Parke County Health Council met October 26 in the REMC building to hear a talk by

GIVE GENEROUSLY TO THE MEDICAL EDUCATION FOUNDATION!

Dr. S. A. Hall, extension veterinarian of Purdue University on how livestock diseases affect human health.

A continued immunization program for children in Bartholomew county schools has been assured through action of the Bartholomew-Brown County Medical Society which voted to raise funds for the necessary vaccine, which formerly was supplied by the Indiana State Board of Health.



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Pan-American Association
Plans Medical Congress

More than 2,500 doctors and medical researchers from 22 nations will exchange information on the latest developments in medicine, surgery and related fields during a 16-day medical congress to be held in six South American cities and aboard ship enroute from New York to those ports. Dr. Charles Crocker, San Francisco, executive secretary of the Pan American Medical Association, announces. The group will sail from New York January 6 and will include 700 United States doctors and their families.

Eighteen original articles devoted entirely to radiation therapy were published in the November issue of the Mississippi Valley Medical Journal and Radiological Review. All articles are written to appeal to physicians in general practice.

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Anesthetic in Hospital.....	10.00	20.00	30.00	40.00
X-Ray in Hospital.....	10.00	20.00	30.00	40.00
Medicines in Hospital.....	10.00	20.00	30.00	40.00
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COSTS (Quarterly)				
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A. M. A. Washington Office News

Dual Registrants Have 30 Days to Ask Reserve Commissions. Selective Service has instructed local draft boards to give physicians registered both under the regular and doctor drafts 30 days in which to make application for a reserve commission, once they are called up. The agency said applicants, in applying on a form supplied by their boards, may indicate their first and second choice of service. Selective Service adds that the military department involved will notify the state director of Selective Service of any registrant who doesn't accept a commission within 30 days after it is tendered. Such registrants would then face early induction as privates.

House Committee Hearings Halted After Insurance Groups Testify. The House Interstate and Foreign Commerce Committee health hearings were halted October 14 after two days of testimony on the extent of health insurance coverage in the U. S. Three days of hearings at which Blue Cross, Blue Shield, labor groups, and others were to testify were cancelled. Chairman Charles Wolverton of New Jersey explained the committee had gathered so much material since it began hearings October 1 that the time had come to stop and analyze the testimony to date. He said the hearings undoubtedly would be resumed at some future date. However, he set no definite time for resumption.

Major insurance companies outlined the progress of health insurance in the U. S., which was described by a witness as the most rapidly growing type of voluntary social insurance the world has ever seen. At the turn of the century 47 companies were writing insurance, with 463,000 policies in force. Today about 800 insurers are providing accident, health, hospital, and medical expense insurance, another witness stated.

They testified that more than 91,000,000 men, women, and children now have hospitalization protection, 73,000,000 have surgical expense coverage and 36,000,000 are protected for medical expense. Last year about \$1 billion was paid by voluntary health plans for hospitalization, \$500 million for surgical and doctors' bills and another \$500 million in benefit payments to replace family income lost through sickness or injury.

Edmund B. Whittaker, vice president of Prudential Insurance Co., estimated about a million persons are now covered for catastrophic illness and that experience demonstrates that "everybody wants this coverage." This type of insurance can only hope to succeed with the "intelligent cooperation of the medical societies and the doctors themselves . . . This insurance is not a bonanza to increase the cost of medical care. It is being provided to enable the public to voluntarily insure its health risks."

Witnesses from both insurance companies and business firms with health plans stressed the importance of *the voluntary approach*. Typical was the testimony of James C. Christy, insurance manager of the Upjohn Co.: "It is fortunate that the voluntary health insurance market is flexible enough to permit us to buy what we want, and other employers to buy what they want. The important thing is to recognize that corporations have individualities and need freedom to work out the insurance programs which suit them best."

More Liberal Tax Deductions Proposed for Medical Care Costs. When Congress reconvenes in January it may be asked to liberalize federal income tax deductions for medical expenses.

(Continued on Page 1292)

this story concerns an unnamed canyon which houses a four-level ruin, the home of primitive men for thousands of years . . . a hoosier doctor is the narrator . . .



PHOTO 1

AENIGMATA

CAN IT BE BELIEVED that there are remote places in our land so well hidden that no living man has left record of his passing?

Is it any easier to think that an earlier man, long since lost to limbo, lived there in undisturbed peace for more than a millenium?

Too bad we didn't learn of this place and of these men long ago,—because both were found in Monument Canyon, Arizona, by the writer. No record of historic visitation has been uncovered since the revisitation, or discovery, in the 1930's.

Monument Canyon ends in upper DeChelly (the French spelling of the Spanish pronunciation of the Navaho word for canyon, "tsegi".) This region is above most of the ruins left by the early cliff dwellers, now mapped completely by DeHarport. No other ruin worth the name is within miles of the hidden box canyon in which the "Ladder Ruin" stands. There is no logical reason to search the area for prehistoric man's leavings.

A recalcitrant Navaho horse, truest "crow bait", put me afoot near Spider Rock. The rest of the party had no patience and so no apparent observation of the plight of the Hoosier tenderfoot. They rode on to be gone for the day.

Since most of archeologic reconnaissance is written in frustration and failure to find anything, the unexpected can pop up anywhere. A rock fall that had no business to be where it was promised another canyon that was on no map. That canyon lay behind a talus slope a hundred feet high, and had a stream in its bottom. Winding back from the barrier the small unnamed canyon is full of great yellow pine, and its walls rise abruptly to about 1500 feet. Five hundred yards back from Monument Canyon there is a cave shaped like the graceful long necked water jug. In the body of the jug is a four-level ruin that contains a row of well preserved slab houses of the "Basket Maker" man, and on the lower levels are the rock and mortar houses of the typical cliff dwellers—something like Mesa Verde.

Closer acquaintance brought into view something that may not show very well on half tone copies of the photographs; ladders made by cutting steps into large logs. Now come the real questions: were the logs cut by historic man, an unknown with a steel axe? Were they cut

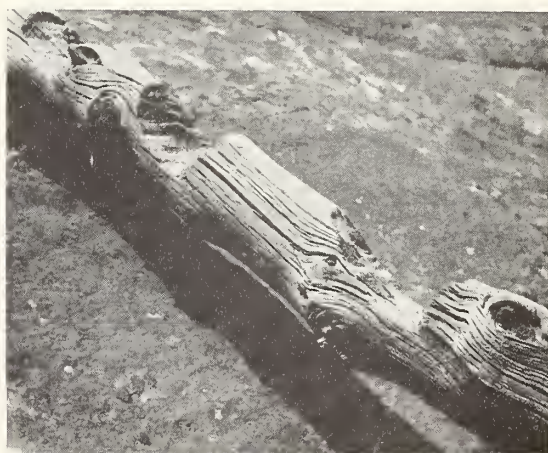


PHOTO 2

by the old stone axe and fire, as earliest man did? How were the logs dragged up the very difficult approach to the ruin? . . . and so runs the mind when alone with the very ancient past.

Photo No. 1 is of the ruin from inside the great cave. Deep shade destroyed contrast in light, but there is one ladder leading up from the building just to left of center. The other ladder is behind a bush below center. Both are marked by circles. Both served to lead the visitor from one level to the next, as can not be shown in the two dimension limitation of photography.

Photo No. 2 is of the lower log. It has been protected from the weather, and when Dr. Douglas gets at its tree ring chronology we will have no doubts left. Until then, the pleasure of speculation and deductive reasoning is ours. What penalty can there be here for mistake? This offers welcome relief from medicine, therefore.

The lower log ladder leads to a very shallow hand and toe trail that in turn runs out over the



PHOTO 3

edge of a precipice (the dark shadow to the right in photo No. 1). Entrance by uninvited visitor could not have been effected in the days of the stone age. When we study the plains tribes and see that they wandered far and fiercely, it is no wonder that these peaceful and agricultural cliff dwellers built for safety against just such accident. No doubt, in that earlier day, the rock fall did not disguise or hide the entrance into that beautiful little canyon and the homes in the cave. Lookout towers cunningly hidden allowed watchers to give ample warning to field workers; there being no horse or auto travel and no such thing as fast approach for surprise.

Photo No. 3 is of another canyon home, considerably more exposed to open country. Here a mock wall and square door were built at the end of a single track hand and toe climb of about 80 feet. Loopholes were so fixed that a spear held dominance of every foot of the climb. Visitors kept their manners in that day.

"In the stone age", it has been written, "there

were no forts made by the peaceful early men." These photos show a different story, and also show a different need. No long range weapon then permitted men to protect themselves and their families very simply. Enemies could be kept at a distance; a distance that allowed exchange of amenities and compliments,—but no wounds.

The trail of prehistoric man leads through many problems for a modern inquisitive mind. How could such a virile people live on such simple fare? We know their dietary limitations, and their pathologic purity,—relatively. No processed foods, no dairy products, no supplemental vitamins, no plumbing, no soft beds, no wool, no metal, no transportation or communication,—no medicine!

It is written in broken pottery that varieties of these people lived side by side in peace for several thousands of years. The same caves were continuously inhabited through the slow change from most primitive man into the understanding of mechanical principles and the development of the atlatl. Then a golden day came when the bow and arrow gave man the chance to secure meat from a safe distance. All during this time, men lived in the "Ladder Cave" and its ruins as we see them now. They cut their logs with stone axes, using fire to help the dull stone edge.

Here do we have evidence of the quality of workmanship made in such manner, as we believe we do,—or was this piece of work done by some itinerant modern man of long ago, who left no note of his visit? And why should he visit this empty home of a people who had no things worth the effort of dragging such a log so far?

The questions that pose themselves to contemporary observers bring acquaintance with a way of life that is far different from ours. We guess at answers. Changing viewpoint and added information change conclusions, so that the story of prehistoric man becomes similar to the story of medicine. We end up as we do in most science with the definition of truth as the best explanation of the facts at hand; recognizing the paucity of most information source, and welcoming the enigma that poses the challenge.

—T. B. NOBLE.

THE STORY BEHIND "AENIGMATA" . . .

COMMISSIONED by a friend to find some open territory suitable for the raising of cattle young Tom Noble, then 21 and a graduate of Wisconsin University School of Medicine, made his first trip into the southwestern United States in 1916 . . . into the land of the Navaho and the Hopi . . . into the Canyon de Chelly. A national monument now, that canyon has divulged secret after secret to the Indianapolis surgeon who has made a life study of the tragic history of the American Indians, crowded together on small Arizona and New Mexico reservations.

Many times since 1916, he has gone back into the Indian country to explore northeastern Arizona, northwestern New Mexico, and parts of Utah. These archeological trips have led him into ruins, long covered by sand and stone, where 3,000 living rooms furnish one large piece of the puzzle that is Indian civilization. Two parties of government men have visited some of these nearly inaccessible cliff homes which Tom Noble

may have discovered. No others are known to have seen them. All have been authenticated by photographs.

A translation of the Hopi Bible, dictated by members of the tribe, has been recorded by Doctor Noble together with many transcriptions of their traditional ceremonies. He has made a report to the United States Congress giving a detailed analysis of the Hopi land troubles; he has told the story of the obligation placed upon the Hopis by Maasawe, the "Great Spirit".

An active member of the South West Monuments Association, Doctor Noble has great pride in the new headquarters at Globe, Arizona. Attached to the National Park Service, the association extended its work when instruments were supplied for a tape-recorded library of sound which keeps alive the work of men in the anthropological sciences. There are now several thousand recorded tapes of research in the southwest . . . stories never told before . . . stories still incomplete . . . aenigmata. J.S.G.

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Deaths

Amos H. Rhodes, M.D., 75, Princeton ophthalmologist and otolaryngologist for the last 43 years, died on October 15 in Gibson General Hospital after only a few days serious illness. He had planned to participate in the activities of the Fifty Year club at the annual convention of Indiana State Medical Association. His 50-year pin and certificate had been presented to him shortly before he became ill. Doctor Rhodes was a 1903 graduate of Kentucky School of Medicine, Louisville. He established his practice in Milltown, remaining for seven years before returning to medical school for additional work in his chosen specialty. He had been in practice in Princeton since 1912. Doctor Rhodes served as a captain in World War I. He had since been active in his profession and in many civic endeavors. He was a senior member of Gibson County Medical Society and the Indiana State Medical Association.

Earl E. Johnson, M.D., 68, died November 4 in his home in Covington. He had been in ill health for several years and seriously ill one month.

Doctor Johnson was a native of Warren county. He received his degree in medicine from the Southwest School of Medicine and Hospitals, Kansas City, in 1911 and established his practice in West Lebanon. After serving as a lieutenant in the Medical Corps during World War I, Doctor Johnson resumed his practice in Kingman where he remained until 1930 when he moved to Covington. At the time of his death Doctor Johnson was city health officer and examining physician for the Selective Service board. He was a member of Fountain-Warren County Medical Society, the Indiana State and American Medical Associations.

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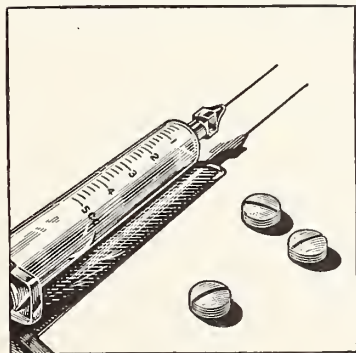
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A.M.A. WASHINGTON OFFICE NEWS

(Continued on Page 1285)

This is one of the suggestions expected to be made by the staff of the House Ways and Means Committee, which has been working on tax amendments since last summer.

Under present law adjusted, taxpayers may deduct only that part of medical expenses in excess of 5% of gross income. The committee staff is considering proposing that this be changed to 3%. It is estimated that the government would lose \$150 million in revenue annually if this restriction is eased.

Another modification under discussion would eliminate the maximum limitation on medical expense deductions. Now it is \$1,250 per year for a single person, \$2,500 for one with one dependent, \$3,750 for a married couple with one dependent, and \$5,000 for a married couple with two or more dependents. It is pointed out that so few persons contract medical care bills of such size that the revenue loss to the government would be negligible. The committee staff also contemplates recommending raising the \$600 earnings limitation on dependents who are students. The suggestion is to lift this ceiling in the case of students, so parents can continue to claim them as dependents even if their earnings exceed the \$600.

VA to Ask Financial Information in Non-Service Connected Cases. Under a new policy, Veterans Administration from now on will ask additional information from a veteran applying for hospitalization of a non-service connected condition. Previously, the veteran had only to answer the question: "Are you financially able to pay the necessary expense of hospitalization or domiciliary care?" If the answer was "no," the veteran was eligible. Now the veteran will be required to answer the following additional questions:

1. What is the current value of your property, real and personal?
2. What is the current amount of your ready assets in the form of cash, bank deposits, savings bonds, etc?
3. If you own real property, what is the approximate amount of the unpaid mortgage or other indebtedness?
4. What are your average monthly expenditures, including mortgage payments and all other personal expenses, including your expenses for dependents?
5. What was your average monthly income for the last six months, from all sources?

However, VA states that, "This addendum may be used in no way whatever to deny hospitalization to a veteran, as the law specifically provides that 'the statement under oath of the applicant. . . shall be accepted as sufficient evidence of inability to defray necessary expenses.' (It) is designed to protect applicants for hospitalization, and veterans generally, from charges of 'chiseling' on the government."

for emotionally disturbed children . . .

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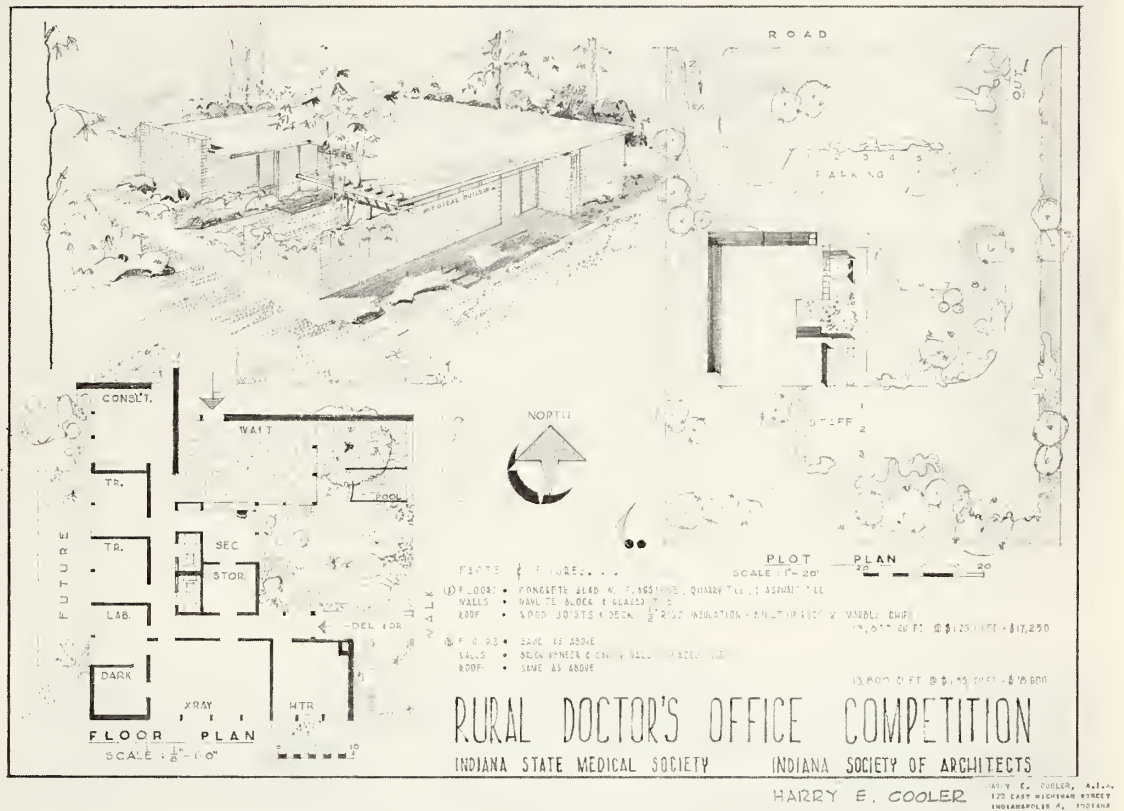
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ATTRACTIVE DESIGN FOR RURAL DOCTOR'S OFFICE HAS MANY PRACTICAL FEATURES



THE ABOVE DESIGN provided one of the best presentations and most attractive solutions of the problem of furnishing suitable office quarters for doctors in rural areas.

The work of Harry E. Cooler, 122 East Michigan Street, Indianapolis, the plan was entered in the competition for designs sponsored jointly by the Indiana State Medical Association and the Indiana Society of Architects. The competition was planned to create and maintain interest of doctors now practicing in small towns and to help attract those just entering private practice to the more sparsely populated areas where doctors are genuinely needed.

Mr. Cooler's plan shows good separation for the secretarial space, without sacrificing control. The committee of judges said relationship of treatment rooms, laboratory, x-ray room and dark room were all good. They found serious fault with the location of the heater room which was isolated to such a degree that it added materially to the cost of heating. Judges added that the plan did not provide adequate room for expansion.

Two choices of exterior wall construction were suggested: one of block and glazed tile, the other of brick veneer and glazed tile. Estimated cost of the first was \$17,250 and of the veneer model \$18,500, based on costs in the Indianapolis area.

News Notes

Dr. Philip A. Boyer, Jr. Joins Pitman-Moore Staff

Appointment of Dr. Philip A. Boyer, Jr., a native of Philadelphia, to the scientific staff of the Pitman-Moore Company, Indianapolis, has been made by Dr. C. A. Bunde, director of research. Doctor Boyer will assist Doctor Bunde in the clinical research program.

After receiving his medical degree from the University of Pennsylvania School of Medicine, Doctor Boyer interned at Abington Hospital, Abington, Pennsylvania. He then served residencies at St. Joseph's Mercy Hospital, Ann Arbor, Sunny Acres Sanatorium, Warrensville, Ohio and the Oakland County Tuberculosis Sanitarium at Pontiac, Michigan. Doctor Boyer was assistant medical director of Roosevelt Hospital, Metuchen, New Jersey, associate director of clinical development for an eastern drug firm and for two years before coming to Indianapolis

was associate medical director for a large laboratory. He was in private practice from 1944 to 1946.

Doctor Boyer is a member of American Medical Association, fellow of the American College of Chest Physicians and the American Trudeau Society.

Members of the medical profession and their families welcomed two new doctors and their families to Richmond at an open house recently in the home of Dr. and Mrs. Morris Wertenberger. The new physicians are **Dr. Roger Hanna**, formerly of Jackson, Michigan, and **Dr. James Passino**, who came from Battle Creek. Doctor Hanna is new superintendent of Smith-Estep Memorial Hospital and Doctor Passino is on the staff of the x-ray department at Reid Memorial Hospital.



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T. N. KENDE, M.D., Neuropsychiatrist, Medical Director

T. J. Smith, M.D., Associate

Dr. Cleon Nafe Panelist At St. Paul Conference

"Physicians' Placement Service" was discussed by Dr. Cleon A. Nafe, Indianapolis, member of the AMA Committee on Extension of Hospitals; Dr. Willard Wright, Williston, North Dakota; and Earl Thayer, Madison, Wisconsin, executive director of public information, State Medical Society of Wisconsin, at the November 1 meeting of the North Central Medical Conference in St. Paul.

States which participated in the conference were Iowa, Nebraska, North Dakota, South Dakota, Wisconsin and Minnesota.

Twenty-five Fort Wayne physicians, all associated with the Duemling Clinic in that city, recently spent two days touring the Parke, Davis and Company home offices and laboratories in

Detroit. They made a complete inspection of the 86 year old company's research facilities.

Dr. Okla W. Sicks, Indianapolis, spoke to the Bloomington Council of Women of the Monroe County Cancer Society October 13, illustrating his talk with colored slides of early and late malignancies and other tumors.

I.A.G.P. Selects April Dates for Annual Meeting

The sixth annual meeting of the Indiana Academy of General Practice will be held in the Antlers Hotel, Indianapolis, on April 14 and 15. The annual banquet will be held on April 14. The annual business meeting is also scheduled for that date with the Founders Lecture following on April 15.

Dr. Maurice V. Kahler is chairman of the committee planning the annual meeting.



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Ophthalmology Research Meeting February 7

The Midwest Section of the Association for Research in Ophthalmology will hold its annual meeting Sunday, February 7, at the University of Chicago, School of Medicine, Chicago 37, Illinois.

Papers of clinical and basic interest will be presented with many presentations of a preliminary nature, according to Dr. Frank W. Newell, secretary-treasurer of the association.

Dr. Theodore F. Schlaegel of the Department of Ophthalmology, Indiana University School of Medicine, is chairman for the meeting.

Annual clinical conference of the Chicago Ophthalmological Society will be held in the Drake Hotel, Chicago, on February 5 and 6.

Dr. Harry Silvian, Whiting, has returned from New York where he completed a course in recent advances in surgery in the Postgraduate Medical School of New York University-Bellevue Medical Center.

Dr. David A. Bickel and Dr. Jene Bennett of the South Bend Medical Foundation presented a paper on "Rare Mesodermal Tumors of the Uterus and Vagina" at the annual meeting of the Central Association of Obstetricians and Gynecologists in Houston, Texas recently.

The American Association of Blood Banks elected Dr. Merlin L. Trumbull, Baptist Hospital, Memphis, as president-elect at the recent sixth annual meeting held in Chicago. Dr. Aaron Kellner, New York, is the 1953-54 president.

Eleven colleges and universities received grants to support research projects recently, an Eli Lilly and Company release reports. Recipients were: University of Notre Dame, University of Chicago, Cornell University Rice Institute, University of Southern California, State College of Washington, Washington University, State University of Iowa, North Texas State College, Northwestern University and Western Reserve University.

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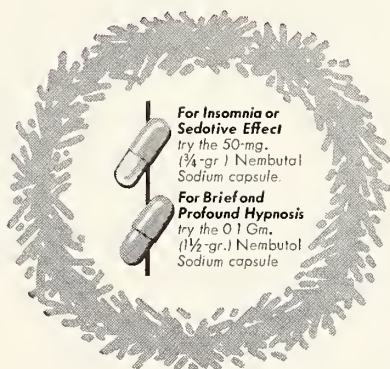
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Gastroenterologists Elect; Set Convention Date

More than 500 physicians attended the eighteenth annual convention of the National Gastroenterological Association held October 12 in Los Angeles. Dr. Sigurd W. Johnsen, Passaic, New Jersey, assumed the presidency. President-elect is Dr. Lynn A. Ferguson, Grand Rapids, Michigan.

The 1954 convention will be held in October in Washington, D.C.

Dr. Chester A. Stayton, Sr., Indianapolis, attended the annual meeting of the board of directors of the American Cancer Society as a delegate member from Indiana. Dr. and Mrs. Stayton returned to Indianapolis after visiting Washington, D.C. and Williamsburg.

Dr. George O. Parks has reopened his office for the general practice of medicine in Hartford City. He has just completed two years service in the U. S. Air Force. His offices at 302 North High Street are in his former location.

A continuing annual grant has been presented to the Indiana University Medical Center Library in Indianapolis by Pitman-Moore Company, Indianapolis drug firm. The funds will be used for the purchase of volumes to fill gaps in periodical files and for purchase of back volumes of medical periodicals.

Dr. Louis E. Fritsch, Evansville general practitioner since 1904, has closed his offices at 1204 North First Avenue, but will continue to care for some of his patients. "Many of them are older than I am and have been coming to me for years," he said. Doctor Fritsch attended the annual convention of I.S.M.A. at French Lick in October where he received his Fifty Year Club pin.

Dr. Henry Alderfer, Marion, was the featured speaker recently at a Grant County Farm Bureau meeting. He discussed "Heart Diseases."

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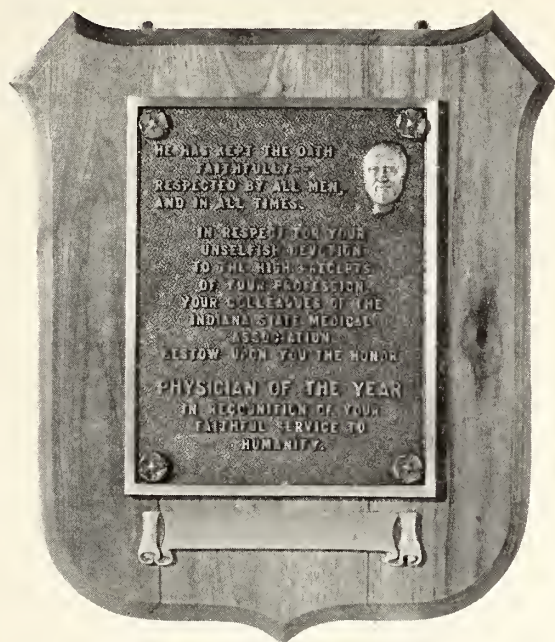


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I.S.M.A. Plaque



The above newly designed bronze plaque, mounted on a walnut shield, will be presented each year to the Indiana physician who is judged by the House of Delegates to have given the most outstanding and unselfish devotion to the high precepts of his profession.

Dr. Joseph Plant, native of Delphi, has been named chief surgeon at the State Soldiers' Home at Lafayette, and assumed his duties on October 15. He is a veteran of both wars and has spent 32 years in government service.

Dr. Harvey W. Garrison and **Dr. J. J. Mathewson**, now stationed at Camp Atterbury with the Medical Ordnance department, have opened an office in Hope where they will have evening office hours from 6 to 8 o'clock every evening except Sunday and Saturday afternoon hours from 2 until 5. They will make house calls. Both doctors are natives of Illinois and both plan to move to Hope with their families.

Dr. John D. Karns, native of North Manchester, and a 1952 graduate of Indiana University School of Medicine, has opened an office in Winamac. Doctor Karns recently completed his

internship at Miami Valley hospital, Dayton, Ohio. He is a World War II army veteran. Dr. and Mrs. Karns have converted a recently purchased home into a combined office and residence. Mrs. Karns is a registered nurse.

Dr. George S. Row, Osgood, chairman of the surgery staff of Margaret-Mary Hospital in Batesville, recently completed a course in the review of general surgery for specialists at the Postgraduate School of New York University-Bellevue Medical Center.

Appointment of **Dr. Fred W. Tempy** as assistant superintendent of Norman Beatty Memorial Hospital, Westville, has been announced by Dr. W. R. Van Den Bosch, superintendent. Doctor Tempy is an Indiana University School of Medicine graduate, spent two years in the Army Medical Corps during World War II, interned at Marine Hospital in Detroit, and recently completed a two year residency at Norways and the Veterans Administration hospitals in Indianapolis.

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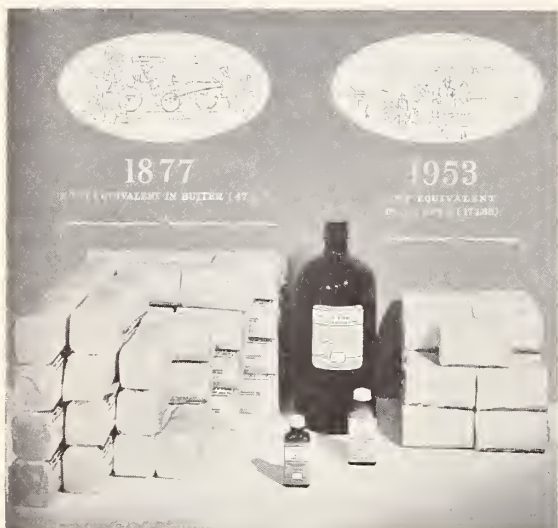
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Society Reports

MEETINGS OF THE EXECUTIVE COMMITTEE, THE COUNCIL, AND THE HOUSE OF DELEGATES HELD DURING THE 104th ANNUAL CONVENTION OF THE INDIANA STATE MEDICAL ASSOCIATION ARE REPORTED ON THE FOLLOWING PAGES. HOUSE OF DELEGATES SESSIONS ARE COMBINED TO GIVE COMPLETE ACTION ON EACH ITEM OF BUSINESS

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

October 18, 1953

Roll call showed the following present: W. L. Portteus, M.D., chairman; James W. Denny, M.D.; Paul D. Crimm, M.D.; W. H. Howard, M.D.; E. R. Clarke, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump and Robert Hollowell, attorneys; J. A. Waggener, executive secretary; R. J. Amick and K. W. Bush, field secretaries.

Minutes of the meeting of September 13, 1953, were approved by consent.

Membership Report

Number of members October 16, 1953.....	3,781*
Number of members October 16, 1952.....	3,699
Gain over last year.....	82
Number of members December 31, 1952.....	3,786

* Includes 143 in military service (gratis)

109—\$10.00 members (residents and interns)

251—senior members

75—members, dues remitted by Council

Number who have paid AMA dues:

1951	2,997
1952	3,569
1953	3,591*

* 420 members who were permanently exempted in 1952 are included in above figure.

Headquarters Office

The Executive Committee requested the field secretaries to check the availability of Congressmen who are home on vacation and relay this information to the appropriate county medical societies, urging that they invite the Congressmen to attend county medical society meetings.

By consent, it was agreed that the Executive Committee would suggest to the Council that the

Council in turn suggest to the House of Delegates that the county medical societies make it a point to meet with their Congressmen prior to the opening of the next session of Congress.

The secretary presented the committee with clippings showing the publicity received by various county medical societies over the state during the past month.

The cost of the telephone conference held by the Executive Committee with members of the Council was presented to the committee.

Future Meetings

On motion of Drs. Denny and Howard the Executive Secretary is to attend the American Public Health Association meeting in New York, November 9 to 13, 1953.

Statements of receipts and expenditures and report on the budget for July, August and September for the Association and *THE JOURNAL* were approved.

1953 Annual Convention, French Lick, October 19, 20 and 21, 1953

The committee briefly reviewed the resolutions to come before the House of Delegates, the secretary presenting the request of the secretary of a Joint County Medical Society to permit a physician from one county to act as a delegate representing the physicians of the joint county, and the committee, by consent, prepared a recommendation for the Council to amend the bylaws clarifying this matter.

Organization Matters

Interim session of House of Delegates. A report of the survey of the component county medical societies relative to their opinion concerning the continuation or discontinuation of the interim session was presented and, by consent, was to be referred to the Council.

Use of mailing list by Indiana Academy of General Practice. The request of the Indiana Academy of General Practice for use of the association's mailing list for the purpose of addressing an invi-

tation to association members to the annual meeting of the Academy was granted, on motion of Drs. Myers and Clarke.

Conference of Presidents. Payments of \$75.00, 1954 annual dues to the Conference of Presidents, was approved on motion of Drs. Howard and Crimm.

The executive secretary is to attend the meetings of the Better Business Bureau, Inc., October 28, 1953, and the Indiana State Chamber of Commerce, November 24, 1953, both in Indianapolis, if time permits.

The Journal

Report on advertising was accepted by consent:

Total, September, 1952	\$2,063.18
Total, September, 1953	\$2,171.91
October, 1952	\$2,910.78
October, 1953	\$3,465.41

10-month totals	
1950	\$22,265.02
1951	\$23,477.28
1952	\$22,279.32
1953	\$23,673.32
Gain over 1952	\$ 1,394.00

New Business

By consent it was agreed that the program of the annual convention should be sent to every member well in advance of the meeting and publication in THE JOURNAL.

There being no further business the meeting adjourned to meet again at 11:00 a.m., November 15, 1953, at the new Service Center Building, Indiana University Medical Center, Indianapolis.

THE COUNCIL

(French Lick Session, 1953)
First Meeting

The first meeting of the Council was held in the Hunt Room, French Lick Springs Hotel, at 3:00 p. m., Sunday, October 18, 1953, with Dr. Elton R. Clarke, the chairman, presiding. Roll call showed the following present:

Councilors:

First District	Herman T. Combs, Evansville, Paul D. Crimm, Evansville, alternate, and president Minor Miller, Evansville, councilor-elect
Second District	A. G. Blazey, Washington
Third District	William H. Garner, New Albany
Fourth District	Charles Overpeck, Greensburg J. E. Dudding, Hope, councilor-elect

Fifth District	M. C. Topping, Terre Haute V. Earle Wiseman, Greencastle, alternate
Sixth District	W. U. Kennedy, New Castle Harry P. Ross, Richmond, alternate
Seventh District	Roy A. Geider, Indianapolis Lester D. Bibler, Indianapolis, councilor-elect
Eighth District	T. R. Hayes, Muncie Gordon B. Wilder, Anderson, alternate
Ninth District	Wemple Dodds, Crawfordsville
Tenth District	J. Robert Doty, Gary James P. Vye, Gary
Eleventh District	Elton R. Clarke, Kokomo
Twelfth District	Maurice Glock, Fort Wayne
Thirteenth District	Kenneth L. Olson, South Bend G. O. Larson, LaPorte, alternate

Officers:

Paul D. Crimm, Evansville, president
W. Harry Howard, M.D., Hammond, president-elect
Roy V. Myers, Indianapolis, treasurer

Journal:

Frank B. Ramsey, Indianapolis, editor of THE JOURNAL
Stephen Johnson, Evansville, Associate Editor of THE JOURNAL

Executive Committee:

Walter L. Portteus, Franklin, chairman
James W. Denny, Indianapolis
Albert Stump, attorney
Robert Hollowell, attorney
Robert J. Amick, field secretary
Kenneth Bush, field secretary
J. A. Waggener, executive secretary

Delegates and Alternates to A. M. A.

Wendell C. Stover, Boonville, delegate
Cleon A. Nafe, Indianapolis, delegate
E. S. Jones, Hammond, delegate
Alfred Ellison, South Bend, alternate
William C. Wright, Fort Wayne, alternate

Guests:

Paul R. Tindall, Shelbyville, secretary, State Board of Medical Registration and Examination
J. William Wright, Indianapolis
Charles E. Gillespie, Seymour
John Paris, New Albany
Seth Ellis, Anderson
John B. Twyman, executive secretary, Lake County Medical Society, Gary

Minutes of the July 19, 1953, meeting of the Council, held in Indianapolis, were approved by consent as printed in the September, 1953, JOURNAL.

Dr. Geider introduced the newly elected Seventh District councilor, Dr. Lester D. Bibler, Indianapolis.

Dr. Doty announced that the councilor and alternate councilor of the Tenth District had been re-elected at the recent district meeting.

District meetings were reported scheduled as follows:

Third District	Jasper, May 26, 1954
Fourth District	Seymour, May 5, 1954
Fifth District	Terre Haute, May 19, 1954
Eleventh District	Marion, May 19, 1954
Thirteenth District	South Bend, November 18, 1953

Unfinished Business

1. *Indiana licensing regulations.* Dr. Dodds, chairman of the Council Reference Committee on Educational Affairs, presented the following recommendation, compiled by his committee, which was adopted on motion of Drs. Dodds and Doty:

That a committee be appointed to confer with the State Board of Medical Registration, with the view of seeking the adoption of a procedure by regulation or other legal means, whereby an applicant for an unlimited license to practice medicine who has all the qualifications to take the Board Examination therefor and who is not eligible for a certificate by reciprocity, may be issued a temporary permit or successive temporary permits covering the period from the date of application until the next Board Examination.

This subject was discussed by Mr. Stump, Mr. Hollowell, Drs. Doty, Dodds, Tindall and Glock, and on motion of Drs. Dodds and Doty the Council voted to accept the following suggestions in place of the above recommendation and the resolution on medical licensure printed on page 86 of the Handbook:

Suggested Rules:

That there shall be two regular meetings of the Board each year, one on the second Tuesday in January and one the second Tuesday in July. Special meetings shall be on the call of the Chairman and only business referred to in the notice may be considered at such special meetings.

The Secretary of the Board is authorized to issue a temporary permit to practice medicine to an applicant therefor who has filed an application to take the next available examination for a certificate for an unlimited license to practice medicine, with the fee of \$25.00, if such applicant furnishes satisfactory proof that he has the requisite qualifications, under the law and regulations, to take such examination and is not eligible to a certificate by reciprocity. No more than two successive temporary permits shall be issued to the same person. A person filing a second application, who has previously filed an application to take such examination and paid a fee of \$25.00, but who has not taken such examination, shall not be required to pay an additional fee with the second application.

2. *Hospital accreditation.* Dr. Geider, chairman of the Council Reference Committee on Nursing and Hospital Problems, presented the following report:

The matter of Hospital Accreditation was referred to our Committee by the Chairman of the Council following a brief discussion of this subject at the last Council meeting July 19, 1953.

This report will not attempt to review the history or organization of the Joint Commission on Accreditation of Hospitals. However, a copy of the By-Laws of the Accreditation Commission and a copy of their Standards for Hospital Accreditation as of April 19, 1953 are hereby attached as a part of this report.

For brevity and clarification, the objections and fears entailed in this matter of Hospital Accreditation reduce themselves to two main facets for consideration as follows:

Number One. **OBJECTIONS TO SPECIFIC REQUIREMENTS AS LISTED IN THE STANDARDS FOR HOSPITAL ACCREDITATION.**

a) The requirement relative to General Practice. This requirement as it is now stated in the Standards Manual by omission deprives the General Practitioner of

clinical rights within the hospital except as permitted by the various departments within the hospital staff or a credentials committee. This is entirely due to ambiguity in the wording of the requirement and probably not the intent of the Joint Commission on Accreditation.

b) The requirement on attendance at meetings of the hospital staff by the General Practitioner is likewise worded indefinitely.

The above controversial points have been covered by Resolutions from the Indianapolis Medical Society and will be introduced in the House of Delegates.

c) Mandatory consultations. The chief aim of this requirement is to reduce unnecessary surgery.

Compulsory consultation is an indignity to both the profession and the patient. It tends to undermine public confidence in the medical profession. Consultations where indicated to serve the patient with better medical care have always been welcomed and insisted upon by both the patient and the profession. As to the aims of compulsory consultations, there is no disagreement; but surely they could better be accomplished by a functioning Tissue Committee already required by the Commission.

d) Voluminous history and chart making requirements. Many of the dissatisfactions regarding medical records blamed on the Joint Commission on Accreditation are actually the result of too literal interpretation and application of the Requirements on the part of the individual hospital.

Number Two. **THE SECOND PHASE OF THIS PROBLEM.**

This is much the more serious for it consists of objecting to the entire present set-up of the Joint Commission on Accreditation on the grounds that it is an undemocratic, dictatorial, autocratic and bureaucratic organization from whose decisions there is no appeal except to the Commission itself. This has brought forth considerable clamor both vocal and in the Indianapolis press for local or state level accreditation for hospitals. A close study of the By-Laws will reassure most dissenters.

After considerable thought, discussion and study, it would seem that most of the fears and objections are based on possible anticipated actions of the Joint Commission in the future; for example, closed hospital staffs by way of a requirement that hospital staff membership be limited to Specialty Board Members such as has been done in the Veterans Administration hospitals. Or limitation of the size of a hospital staff depending on bed capacity, etc., etc. The basis for such projected fears and thinking lies in the belief that the Commission is almost a law unto itself. However, faith in the integrity, fairness, and good judgment of the representatives on the board make such actions only a very far remote possibility. The high quality of the present representatives on the board, their high purpose and sincerity are certainly worthy of our confidence and approval. The same may be said for the Advisory Committee to the Board. This Committee is composed of the chief administrative officer of each of the component members of the Joint Accreditation program.

A tremendous amount of work and study has gone into the formation of the Joint Commission on Accreditation as evidenced by its By-Laws. It is a new organization with high ideals and a purpose with which we cannot help but agree. It can be expected to become more practical, more reasonable, more amenable to suggestion, once it has had to wrestle with the many problems bound to beset it. For this Board to ignore the influence, and not seek the advice and guidance of the A.M.A. and other component members of the accreditation organization would be a most irrational and improbable line of action. Furthermore, it must be remembered, both by the medical profession and the Joint

Commission, that participation in the accreditation program is and should be an entirely voluntary one on the part of any hospital.

It would seem to this committee of the Council that accreditation on a local or state level would leave much to be desired in co-ordinating it with a national level program.

RECOMMENDATIONS

The committee makes the following recommendations:

(1) That the Indianapolis Medical Society Resolutions be adopted; a copy of which is hereby attached.

(2) That the above resolution be amended to include omitting mandatory consultations, except where required by law or rules of hospital.

(3) Adoption of paragraph 3 of the resolution on accreditation as introduced by the Standing Committee on Medical Education and Hospitals.

(4) Approval of national level accreditation.

(5) Approval of the aims of the Joint Accreditation Commission and appreciation of the tremendous work done by that Commission.

(6) Close liaison be established between the Indiana State Medical Association and the National Joint Commission on Accreditation for mutual help and co-ordination. That this co-operation be handled through our standing State Committee on Medical Education and Hospitals. To avoid being an ineffectual minority that this entire problem be studied with the aim of determining the attitudes of the other state organizations, and if necessary presenting a united front of protest where indicated.

Respectfully submitted,

ROY A. GEIDER, M.D., *Chairman.*
W. U. KENNEDY, M.D.
M. C. TOPPING, M.D.

The Council approved each of the above six recommendations with separate motions by Dr. Geider, seconded by Drs. Overpeck, Combs, Hayes and Olson.

3. *Committee on Medical Court Testimony.* The names of Drs. Russell W. Lavengood, Marion (Eleventh District), and Lynn W. Elston, Fort Wayne (Twelfth District) were presented for membership on this committee.

4. *Resolutions to be presented to House of Delegates, as result of actions taken by Council at previous meetings:*

a. *H. J. Res. 123, from Council Reference Committee on Public Policy and Legislation, Dr. Blazey, chairman.* (See page 1321, House of Delegates minutes).

b. *Cline report, regarding osteopathy situation.* (See page 1319, House of Delegates minutes).

c. *Continuing Liaison Committee with the Indiana Department of Public Welfare.* (See page 1324, House of Delegates minutes).

5. *Interim session of House of Delegates.* The chairman of the Executive Committee reported that a survey of the county medical societies showed that 43 societies, representing 1,679 members and 63 delegates, favor discontinuing the

interim session of the House of Delegates; 10 societies, representing 1,132 members and 29 delegates favor continuing the interim meetings, and 27 county societies did not vote. On motion of Drs. Dodds and Glock the Council voted to recommend to the House of Delegates that the interim meetings of the House be discontinued.

6. *Pre-Council meetings.* Dr. Kennedy reported that a postal card survey showed 7 in favor of discontinuing and 3 for continuing pre-Council meetings in the districts. As a result, on motion of Drs. Kennedy and Garner, the Council voted in favor of discontinuing these meetings.

On motion of Dr. Geider, duly seconded and carried, a copy of the agenda for Council meetings is to be sent not only to the councilors but also to the officers of each county medical society, that is, the president and secretary, and to the delegates.

New Business

1. *American Medical Educational Foundation.* Dr. Denny, chairman of the Committee on Medical Education and Hospitals, reported that \$87,000 had been sent to the American Medical Education Foundation and \$81,000 plus is now in the Fletcher Trust Company trust fund. The committee has set a goal of \$50,000 for 1953.

2. *Matters referred to Council by Executive Committee:*

a. Recommendation that delegates be instructed to urge their county medical societies to invite their Congressmen to their society meetings to discuss legislation of interest to the profession and that the field secretaries contact Congressmen regarding their availability for such meetings and give this information to the respective county medical societies approved by consent.

b. The Council approved the following amendments to the by-laws, which are to be referred to the House of Delegates:

(1) *Clarification regarding apportionment of delegates to joint societies.* RESOLVED that Chapter IV, Section 2, of the by-laws be amended by striking out the last three lines thereof which read as follows: "each county shall be entitled to at least one delegate to be selected by the physicians residing in such county," and substituting in lieu thereof the following: "Each county shall be entitled to at least one delegate who shall be a resident of the county he represents as a delegate, and who shall be selected by the physicians residing in such county."

(2) *Receipt by headquarters office of resolutions to come before the House of Delegates.* RESOLVED that Chapter IV of the by-laws be amended by adding thereto an additional section to be numbered and to read as follows:

"Section 8. All resolutions to be presented to the House of Delegates for action shall be prepared and mailed to the Executive Secretary of the Association so that he will receive them not later than forty-five days prior to the meeting of the House of Delegates to which the resolution will be presented for action:

Provided, that this sub-section of the by-laws may be suspended with respect to any resolution upon a two-thirds majority vote of the House of Delegates.

c. *Reduction of state association dues.* This matter was presented to the Council without recommendation of the Executive Committee, Dr. Portteus stating reasons for and against reducing the dues. Following discussion by Drs. Crimm, Howard, Myers, Clarke, Blazey, Wright, Olson, Nafe, Doty and Denny, motion of Drs. Olson and Kennedy recommending that the dues be reduced \$10.00 was lost, 7 to 5.

On motion of Drs. Doty and Blazey, the Council voted to recommend to the House of Delegates that the state association dues be reduced \$5.00.

3. *Remission of state dues.* On motion of Drs. Garner, Blazey and Hayes, members of the Reference Committee of the Council on Proposals for Remission of Dues, the dues of a member of the Indianapolis Medical Society and also a member of the Montgomery County Medical Society, both of whom are incapacitated due to illness, are to be remitted.

The Council refused waiver of dues of a member of the Fort Wayne Medical Society who claims financial hardship because he is taking residency training.

4. *Election of JOURNAL editors.* On motion of Drs. Dodds and Geider, Dr. Frank B. Ramsey, Indianapolis, was reelected editor of THE JOURNAL for 1954.

On motion of Drs. Blazey and Olson, the present associate editors were reelected for 1954, as fol-

lows: Drs. A. W. Cavins, Terre Haute; Lall G. Montgomery, Muncie; David A. Bickel, South Bend, and Stephen L. Johnson, Evansville.

5. *Election of Editorial Board members.* Following the reading of a suggestion from Dr. Ramsey, Dr. Kennedy moved that the chairman of the Council appoint a committee to nominate members to serve on the Editorial Board. Motion seconded by Dr. Glock, and carried.

The chairman announced that he would appoint this special committee later, and councilors who wished to nominate members for the Editorial Board should contact these committee members in the future.

On motion of Drs. Blazey, duly seconded, Dr. Samuel Mercer, Fort Wayne, and Dr. George N. Lewis, Gary, were elected members of the Editorial Board to serve for three years, to succeed Dr. Thomas M. Conley, Kokomo, and Dr. C. G. Culbertson, Indianapolis, whose terms expire December 31, 1953.

Date for Midwinter Council Meeting

The Council set Sunday, January 24, 1954, as the date for the midwinter meeting, on motion of Drs. Topping and Blazey. This meeting is to be held at the Service Center, Indiana University Medical Center, Indianapolis.

There being no further business, the Council adjourned to meet again on Wednesday, October 21, 1953, immediately following adjournment of the House of Delegates.

Proceedings of the House of Delegates at the 1953 I. S. M. A. Annual Convention

October 18, 19, 20 and 21, 1953

The House of Delegates convened in the west dining room of the French Lick Springs Hotel, French Lick, Indiana, at 6:30 p. m., Sunday, October 18, 1953, and again at 7:30 a. m. Wednesday, October 21, 1953, with the president, Dr. Paul D. Crimm, Evansville, presiding.

The Reverend Thomas G. Scott, pastor of the Methodist Church of French Lick, pronounced the invocation at the opening of the first meeting.

On motion of Drs. W. U. Kennedy and Lester D. Bibler, attendance slips signed by the delegates were accepted in lieu of a roll call.

REPORT OF REFERENCE COMMITTEE ON CREDENTIALS

A quorum was present at each meeting, Dr. Wendell C. Stover, chairman of the Reference

Committee on Credentials, reporting 134 delegates registered for the first meeting, and 129 present for the second meeting.

The chairman read Chapter XVII, Section 1, of the Bylaws and Article XIV of the Constitution regarding amendments to the Bylaws and the Constitution.

IN MEMORIAM

THE CHAIRMAN: Since the last session of the State Medical Association the following fellow physicians, who were members of this House of Delegates, or who had served the association in an official capacity, have passed away. May we all stand in silent prayer and each one in his own words and in his own way honor the memory of these departed members?

H. H. ALEXANDER, Princeton. Secretary, Gibson County Medical Society, 1946.

- F. H. AUSTIN, Bloomington. Secretary, Monroe County Medical Society, 1921 through 1932; delegate from Monroe county, 1934 and 1943.
- MAX BAHR, Indianapolis. Chairman of Committee on Expert Testimony, 1935 and 1936; member of Committee on Mental Health, 1937 through 1946; delegate from Indianapolis Medical Society, 1934 through 1937.
- I. E. BRENNER, Winchester. Secretary, Randolph County Medical Society, 1915 through 1918, and 1943; delegate from Randolph County Medical Society, 1950.
- C. F. BRIGGS, Sullivan. Delegate from Sullivan County Medical Society, 1946 through 1952.
- M. B. CATLETT, Fort Wayne. Secretary, Fort Wayne Medical Society, 1927 and 1928; member of Auditing Committee 1939 and 1940; member of Committee on Industrial Health 1941; member of Committee on Civil Defense 1952; chairman of Committee on Inter-Professional Health Council 1953; delegate from Fort Wayne Medical Society, 1937 through 1948.
- ARCHIBALD CHITTICK, Frankfort. Secretary, Clinton County Medical Society, 1912 through 1916, 1920 and 1943; member of Committee on Physicians' Welfare 1914-1915; member of M-Day Committee 1940 and Veterans' Affairs Committee, 1941 and 1942.
- CYRUS J. CLARK, Indianapolis. Secretary 1933, and chairman 1934, Medical Section; member of Committee on Business Instructional Course 1933; chairman, Committee on Graduate Education, 1934, 1935 and 1936; member, Committee on Graduate Education 1937 and 1938; member, Liaison Committee with Indiana Crippled Children's Bureau 1938; member, Committee on Medical Education and Hospitals, 1939, 1940, 1941, 1943 through 1948; member, Liaison Committee with Indiana State Department of Public Welfare 1939 and 1940; chairman, Pneumonia Committee 1939, 1940, 1941 and 1942; Councilor, Seventh District, 1936 through 1949; chairman, Committee on Medical and Nursing School Scholarships, 1947, 1948, 1949, 1950; member, Committee on Prepaid Medical and Hospital Insurance 1949; member 1950 and 1951, and chairman 1952, Executive Committee; member, Committee on Heart Disease, 1952; delegate from Indianapolis Medical Society, 1934 and 1935.
- S. M. COTTON, Goldsmith. Secretary, Tipton County Medical Society, 1910 through 1913, 1922, 1930, 1931, 1932, 1939; member, Committee on Indigent Medical Care, 1948.
- J. L. DeNAUT, Hamlet. Secretary, Starke County Medical Society, 1942.
- PAUL A. GARBBER, South Whitley. Secretary, Whitley County Medical Society, 1926, 1931, 1932, 1935, and 1945; member, Committee on Civic and Industrial Relations, 1930, 1931, 1932; member, Committee on Graduate Education 1936; member, Committee on Old Age Dependency 1937; member, Committee on Indiana Inter-Professional Health Council, 1944; chairman, Building Committee, 1946; delegate from Whitley County Medical Society, 1934 through 1946, 1950 and 1952.
- JOHN H. HARE, Evansville. Second Vice-President 1925; member, Committee on Postgraduate Study 1933; councilor, First District, 1929 to October, 1934; member, Committee on Mental Health, 1934 through 1944, 1950, 1952; member, Alcoholics Study Committee, 1952.
- W. W. HOLMES, Logansport. Delegate from Cass County Medical Society, 1935; member, Committee on Graduate Education, 1936; member, Medical Economics Committee, 1946; member, Committee on Veterans Affairs and Rehabilitation, 1950 and 1951.
- J. J. JOHNSON, Milltown. Secretary, Crawford County Medical Society, 1922; delegate from Crawford County, 1944.
- JON KELLY, LaPorte. Secretary, LaPorte County Medical Society 1922 and 1923; member, Committee on Expert Testimony, 1936; delegate from LaPorte County, 1934 through 1944, 1946 through 1949.
- ALBERT M. MITCHELL, Terre Haute. Secretary, Vigo County Medical Society, 1921 through 1952; member, 1926 to 1930, and chairman, 1930 through 1950, of Committee on Secretaries Conference; chairman emeritus 1951 of Committee on Conference of County Medical Society Officers; alternate delegate to the American Medical Association, 1936 through 1951; president-elect 1940, and president 1941 of Indiana State Medical Association; member of Executive Committee, 1940, 1941 and 1946; councilor from the Fifth District, 1943 through 1951; chairman of the Council, 1946; member of Budget Committee, 1940, 1941, and 1946; member, Liaison Committee with Indiana State Department of Public Welfare, 1940; member, Committee on Indiana Inter-Professional Health Council 1941, 1945 and 1946; member of Council on Medical Service and Public Relations 1946; member of Committee on Constitution and By-Laws 1951 and 1952; member of Board of Appeals on Patient-Physician Relations, 1952.
- J. W. MORR, Albion. Secretary, Noble County Medical Society, 1908, 1915, 1918, 1919 and 1920; delegate from Noble County, 1935.
- SAMUEL J. PETRONELLA, East Chicago. Member, Committee on Physical Therapy, 1945 and 1946; delegate from Lake County Medical Society, 1950, 1951 and 1952.
- JOHN A. PFAFF, Indianapolis. Member, Committee on Arrangements, 1914-1915.
- MILES F. PORTER, Jr., Fort Wayne. Secretary, Allen County Medical Society, 1916 through 1922; member, Committee on Scientific Exhibit 1916 through 1921; member, Committee on Postgraduate Study, 1931.
- L. B. RARIDEN, Greenfield. Member, Medical Relief Committee, 1946 and 1947.
- C. C. RAYL, Decatur. Secretary, Adams County Medical Society, 1911, 1912, 1913 and 1920.
- THURMAN B. RICE, Indianapolis. Chairman, Committee on Diphtheria Prevention 1930 through 1936; member of Editorial Board, 1933 through 1939; member, Committee on State Fair, 1934, 1935 and 1937; chairman, Committee on Historical Exhibits, 1949; chairman, Committee on History, 1949; member, Committee on Scientific Exhibit, 1950, 1951 and 1952.
- THOMPSON R. RICE, Petersburg. Delegate from Pike County Medical Society, 1937, 1938, 1940 and 1941.
- LOUIS F. ROSS, Richmond. Member, Committee on Scientific Exhibit 1916 and 1917; Second Vice-president, 1924.
- RUSSELL P. SCHULER, Kokomo. Secretary, Howard County Medical Society, 1915, 1916 and 1917.
- W. D. SCHWARTZ, Portland. Secretary, Jay County Medical Society, 1917 and 1918.
- FRANK SINK, Remington. Chairman, Committee on Rural Medical Care, 1949, 1950; member, Committee on Civic Relationship and Community Health Agencies, 1949; member, Committee on Rural Health, 1951; delegate from Jasper-

Newton County Medical Society, 1948 through 1952.

WALDO E. SMITH, Decatur. Secretary, Adams County Medical Society, 1909, 1910, 1926 and 1932.

C. C. SOURWINE, Brazil. Secretary, Clay County Medical Society, 1915 and 1916.

S. F. TEAFORD, Paoli. Secretary, Orange County Medical Society, 1909 through 1912.

WILLIAM F. WALLER, Angola. Delegate from Steuben County Medical Society, 1935, 1938, 1939, 1940, 1941, 1942.

BOAZ YOCUM, Coal City. Delegate from Owen County Medical Society, 1936, 1937 and 1942.

MINUTES OF THE INTERIM

MEETING OF THE HOUSE held April 26, 1953 in Indianapolis were approved as published on pages 526 to 534 of the June 1953 Journal of the ISMA, upon motion by Dr. J. William Wright and seconded by Dr. William B. Challman.

INTRODUCTION OF GUESTS

JOHN BACH, Press Relations Director of the American Medical Association, and official representative of the A. M. A. at this meeting;

THOMAS A. HENDRICKS, secretary of the Council on Medical Service of the American Medical Association;

WILLIS I. LEWIS, M.D., Herrin, Illinois, president of the Illinois State Medical Society, and

KENNETH W. BUSH, Indianapolis, newly appointed field secretary of the Indiana State Medical Association for the northern half of Indiana, were introduced.

ELECTION OF PHYSICIAN OF THE YEAR

DR. JOHN A. SCUDDER, Edwardsport, was elected recipient of the Physician of the Year Award for 1953.

Dr. Scudder is seventy-one years of age, was born and raised in Edwardsport, Indiana, attending grade and high school there. He attended Indiana Medical School and graduated in 1906. Following graduation he returned to his home town of Edwardsport and has practiced there ever since.

At the present time he is still engaged in active practice, making three to six house calls a day in this rural community. However, he tells us that house calls are much less difficult now than they were forty years ago, for it is much simpler to start the car than hitch up the buggy.

Throughout the years he has kept himself informed in regard to new drugs and new methods of treatment and regularly attends all county and state medical meetings. He is now the only physician in active practice northeast of Bicknell

in Knox county and covers an area of about fifteen miles radius around Edwardsport. It is impossible for us to say how many of the population in the northeast section of the county he has delivered, because he is now delivering the third generation, many of them at home.

Certified by:

WILLIAM S. KEEZER, M.D.

Secretary-Treasurer

Knox County Medical Society

APPOINTMENT OF 1953

REFERENCE COMMITTEES

The chairman announced the appointment of the reference committees for the 1953 session as follows, announcing that all reference committees would meet promptly at 9:00 a.m., October 19, in rooms as designated in the announcement of committees, and would continue in session until all business referred to them was disposed of. As names were called each member was asked to rise.

1. Sections and Section Work:

Mezzanine Lounge

Lester D. Bibler, Indianapolis (Marion), chairman
Henry H. Reeder, Jeffersonville (Clark)
Elmer C. Singer, Fort Wayne (Allen)
John R. Wagoner, Delphi (Carroll)
L. B. Chambers, Union City (Randolph)

2. Rules and Order of Business:

Mezzanine Lounge

Donald W. Ferrara, Peru (Miami), chairman
John H. Barrow, Dale (Spencer)
Ernest O. Nay, Terre Haute (Vigo)
Robert Johnson, Rushville (Rush)
Keith Hammond, Paoli (Orange)

3. Medical Education and Hospitals:

North Foyer, Convention Hall

Harry Stimson, Gary (Lake), chairman
James W. Denny, Indianapolis (Marion)
I. E. Huckleberry, Salem (Washington)
G. O. Larson, LaPorte (LaPorte)
Joseph F. Ferrara, Franklin (Johnson)

4. Public Policy and Legislation:

Cavern Room

E. L. Fitzsimmons, Evansville (Vanderburgh), chairman
J. M. Kirtley, Crawfordsville (Montgomery)
Milton Omstead, Petersburg (Pike)
Bernard D. Rosenak, Indianapolis (Marion)
Michael Shellhouse, Gary (Lake)

5. Publicity:

Parlor C

Harry P. Ross, Richmond (Wayne-Union), chairman
G. B. Wilder, Anderson (Madison)
J. William Wright, Sr., Indianapolis (Marion)
Ralph C. Eades, Valparaiso (Porter)
Donald L. Lashley, Tell City (Perry)

6. Hygiene and Public Health:**Room 517**

O. T. Scamahorn, Pittsboro (Hendricks),
chairman
Charles N. Manley, Rising Sun (Dearborn-
Ohio)
Dennis S. Megenhardt, Indianapolis (Marion)
Earl W. Mericle, Indianapolis (Marion)
Walter M. Stout, New Castle (Henry)

7. Amendments to Constitution and By-Laws:**Room 440**

Minor Miller, Evansville (Vanderburgh),
chairman
Alfred Ellison, South Bend (St. Joseph)
T. R. Hayes, Muncie (Delaware-Blackford)
Robert O. Zink, Madison (Jefferson-Switzer-
land)
Jack M. Lockhart, Connersville (Fayette-
Franklin)

8. Reports of Officers:**Room 217**

William B. Challman, Mt. Vernon (Posey),
chairman
A. E. Stinson, Rochester (Fulton)
Max Long, Marion (Grant)
Jerome A. Graf, Bloomfield (Greene)
C. S. Black, Warren (Huntington)

9. Committee on Credentials:**West Dining Room**

Wendell C. Stover, Boonville (Warrick),
chairman
Will A. Thompson, Liberty (Wayne-Union)
Albert Stouder, Kempton (Tipton)
Clark McClure, Knox (Starke)
William E. Amy, Corydon (Harrison-
Crawford)

10. Committee on Miscellaneous Business:**Room 438**

Joseph E. Dudding, Hope (Bartholomew-
Brown), chairman
O. W. Sicks, Indianapolis (Marion)
Philip Yunker, Howe (LaGrange)
R. R. Calvert, Lafayette (Tippecanoe)
Truman E. Caylor, Bluffton (Wells)

11. Committee on Prepaid Medical Insurance:**South Foyer Lounge**

William C. Reed, Bloomington (Owen-Mon-
roe), chairman
Ralph Everly, Indianapolis (Marion)
Robert Rang, Washington (Davies-Martin)
John M. Paris, New Albany (Floyd)
Cleon A. Nafe, Indianapolis (Marion)

ADDRESS OF THE PRESIDENT

The address of the President, DR. PAUL D. CRIMM, was printed on page 1177 in the November, 1953, JOURNAL of the Indiana State Medical Association. This address was referred to the Reference Committee on Reports of Officers and approved by that committee.

ADDRESS OF THE PRESIDENT ELECT

DR. WM. HARRY HOWARD, president-elect, presented the following address, which was re-

ferred to the Reference Committee on Reports of Officers:

Mr. President, fellow members and guests of the Indiana State Medical Association:

It is impossible for me to express in words the feeling of responsibility and appreciation that I have in taking over this office.

My creed is best expressed by Dr. Edgar V. Allen of Rochester:

"I believe in the profession of medicine. I am thankful for that improbable chance that, in an earlier day, took me out of a school of embalming into premedical study. I would rather be of the physician's guild than a follower of any other occupation of which I know. I believe that no profession offers better opportunity for growth in moral and ethical stature, for contribution to the welfare of society, and for relief of individual human suffering. I believe that no profession permits the practitioner to approach so closely the goals of kindness, loyalty, devotion, and consecration as does medicine. If I find, as you must, flaws in the wide surface of the portrait that represents us, I believe them to constitute only a challenge to us to strive more diligently toward perfection."

I have taken as my keynote the expression "Hoosier Physicians Meet the Need." Now if we are to continue to meet the need there are several things we must continue to do.

First, we must have an extension of the use of the Physician-Patient Relations Committee. It is not enough to have such a committee but the public must know of it. They should know, for instance, that this committee is composed of several past-presidents and representatives from the various divisions of the state. It is the province of this committee to consider and if possible to adjust the fee so that it is equitable to both the physicians and the patient. It is part of their duty also to consider any unprofessional conduct of any physician. Many patients' complaints when thoroughly understood turn out to be groundless. On the other hand there is a small percent that should be acted upon by this committee.

Second, continue the Public Relations program. The recent AMA Public Relations Institute made us very aware of the old rule of the thumb, "Whatever is good for the public is good for medicine, and whatever is bad for the public is bad for medicine." Remember that a large part of our program originates in the doctor's office both with the doctor and his office assistants. Here for instance is the time to discuss fees before surgery, OB, or any other major procedure. Why not have the field representative hold meetings with the secretaries and nurses? If need be it could be held at the same time as the Blue Shield meeting.

Releases should be made by our county medical societies of some of the outstanding results obtained in unusual cases. All the great surgery

and cures are not effected at great medical centers. Many are done at the grass roots level. Let us encourage our physicians to take this health leadership in our local clubs, unions, PTA, etc.

The socialization of medicine has been temporarily arrested but there are still small bills being introduced which if passed would do the same thing piecemeal. Therefore we must not let down. I feel that on the national level those men who have demonstrated their friendship for medicine and the public good should be supported no matter what their politics may be.

Our Blue Shield which was started by your organization will pass the million mark in members by this fall. It is the seventh largest in the U. S. A. but we still only have about one-fourth of the state's population enrolled.

I feel further that the medical profession should accept its social responsibility and give more thought to the medical and mental institutions of the State of Indiana. As one of the five members of the Medical Advisory Committee to the Governor, I would like to report a little of the progress that has been made in these institutions. First, the Legislature gave us a 65% increase in operating funds. With this they have been able to increase the number of attendants and with the increased salaries they are attracting many qualified physicians and nurses. Under the old scale it was hard to attract good men to this field.

At the Epileptic Village a team of local doctors assisted by a team from Indiana University School of Medicine examined the 1,100 patients. Out of this examination eight were transferred to the University Hospital with malignancies or other serious disorders and 20% of the total were found to be able to be discharged. The workday and week there was cut from over 12 hours a day, 7 days a week, to 8 hours and work not compulsory.

Many of the institutions were serving meat only once a week. This has been increased to 3 or 4 days a week and milk is now furnished every day.

At New Castle and Muscatatuck diagnostic teams from Indiana and Purdue came in and checked speech and hearing of the whole group. At Evansville insulin shock treatment was instigated for the first time, or at least the first time in many years.

Central State Hospital was completely screened and the premises rid of flies. The New Castle Hospital has had its enrollment doubled in the last three months. Many of these institutions had better records on their dairy cows and pigs than they did on the patients.

Finally the convalescent leaves and home visits have jumped from 900 in the third quarter of 1952 to 1650 in the third quarter of 1953. With the increase in physicians and personnel, Indiana should go a long way up the ladder from our

ranking near the bottom among state institutions in the United States.

We are in favor of the new hospital accreditation board, which consists of American Medical Association, American Hospital Association, American College of Surgeons, American College of Physicians and the Canadian Medical Association, raising the standards but we must never forget that the general practitioner is the backbone of medicine in Indiana and that a place must be kept for him in these hospitals.

There is certainly a need for more young women in the profession of nursing as well as more teachers to give these girls advanced training. Perhaps we can work out a solution with the nursing profession.

Further, we need a continuation and expansion of the indigent care program for it should never be said that anyone lacks medical care in Indiana.

Many of these things are being done and can be pointed to with pride. The promise to the public is that Indiana doctors will continue to recognize their obligation to Hoosiers, to provide them the best medical care, regardless of circumstances and will strengthen their activities to achieve this.

REPORT OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS

Dr. WILLIAM B. CHALLMAN, chairman, presented the following report, which was adopted:

The address of the president-elect was approved with the exception of the paragraphs dealing with the need for more nurses and the expansion of the indigent care program. Your reference committee agrees that more nurses are sadly needed but questioned the advisability of advocating advanced training for all of these. The crying need is not for more supervisors to do paper work but people who are adequately trained to take good care of the sick patients.

Regarding the expansion of the indigent care program, your committee feels we have too much, not too little, of the welfare state in Indiana. It further feels that no one now lacks adequate medical care in this state.

The president-elect is to be complimented on his work with the Medical Advisory Committee to the Governor.

ADDRESS OF PRESIDENT OF WOMAN'S AUXILIARY

MRS. W. BURLEIGH MATTHEW, president of the Woman's Auxiliary to the Indiana State Medical Association, presented the following report which was referred to the Reference Committee on Reports of Officers:

Twenty-six years ago the Woman's Auxiliary to the Indiana State Medical Association was organized with two prime purposes in mind: to promote a

friendlier relationship between physicians' families and to assist the Medical Society at its direction.

For several years many of its activities were purely social but in the past few years we have found the Auxiliary has been forced through necessity to become a stronger service organization. In every community you will find physicians' wives busy with their school, church and many service organizations; but due to the bad publicity given the medical profession recently, you will very often hear it said, "Dr. So and So's wife has never done anything for our community." We have found that more credit is given Auxiliary projects as doctors' wives working together, whereas our individual work in other organizations is very often forgotten.

For example, just recently in Indianapolis during our Hospital Development Drive the Indianapolis Medical Auxiliary through its efforts gave \$1,000 to the fund. I happened to overhear a conversation in which someone said, "Well, at last the doctors' wives in Indianapolis decided to do something." Yet we had all given through other organizations and our husbands had personally contributed, and still we had not received any credit in the public's eye for this.

A few years ago I personally had quite a heated conversation about socialized medicine with a friend of mine and she finished the conversation with these words, "If you do not want government control of medicine you and your group had better do something about it." I have often thought about this and just recently realized that the Medical Society had found an answer for this through the "American Medical Education Foundation."

We, as Hoosier doctors' wives, are truly proud of the fine record you have made with the A. M. E. F. and we do not wish to detract from it in any way. But we only hope we can show in our small way that the wives of the Indiana doctors are in favor of the American Medical Education Foundation, too. Last year through fund raising projects and contributions, the Auxiliary gave \$1,600 to the A. M. E. F. and we are hoping for an increase this year. We have thought of a small token which we might all use and which would add prestige to the fund and still give it good publicity. We have had printed memorial cards which we can all use as a token of sympathy at the time of a death to replace the long overdone habit of flowers which are often expensive and yet so utterly useless. These will be sent to every county auxiliary so they will be readily available to be used at the time they are needed. We feel that the family of the deceased will appreciate the fact that the doctor and his family have thought enough of them to send a gift contribution to the A. M. E. F. which furthers the cause of medicine. The memorial token, no matter how small, can be given to the county treasurer of the medical auxiliary, who in turn will send it to our state treasurer. All of our contributions are earmarked for the Indiana University Medical School Foundation.

As you know, Vanderburgh County Medical Society, working with their Auxiliary last year, put the A. M. A. publication, "Today's Health" in their barber and beauty shops in Evansville. They felt it a good public relations gesture to make the magazine available to the public and there could be no better place for the magazine to be placed, with the exception, of course, of all of our schools so that the children have the opportunity of reading authentic medical articles which they can use in writing their health papers. We have learned to realize that the public truly enjoys reading health articles and we are hoping Indiana will ring with quotations from "Today's Health" this year instead

of the public constantly quoting "Reader's Digest." Let me explain here and now that we have been asked by the Medical Association to sell the magazine and it has never been our idea to be magazine saleswomen; but if that is what they want us to do we are willing to do our part. This year, in order to try to sell the magazine, we have set up a booth manned by Auxiliary members. Stop by and inquire about our Christmas offer, and send a year's subscription to an old school teacher, or your child's present teacher, perhaps your minister, priest or rabbi, or a friend. You might as well do your Christmas shopping early! Each County Auxiliary will receive credit for your subscription. And remember when you renew your own subscription, be sure to mark on the renewal, "Give Indiana Auxiliary Credit."

Just recently while talking to our first grader's teacher we found out she was married to a doctor. Our Jimmy (six) said, "Why, Mrs. Burns, I didn't know you were married to a doctor." Whereupon she said, "Yes, Jimmy, I am." Then our Jimmy replied, "Well, Mrs. Burns, I know just how you must feel; we're married to one, too."

Taking as a basis Jimmy's words, we are all Auxiliary members because we are married to one, too. We are always anxious to do our part if we are needed, but, being married to doctors, we will refrain from interfering until we are needed. We have only the greatest respect and admiration for your group and will always be ready to assist when we are called upon.

REPORT OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS

Dr. William B. Challman, chairman, presented the recommendation of the Committee that the remarks of the President of the Woman's Auxiliary be adopted. Carried.

MATTERS REFERRED TO THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS

The following matters were referred to the Reference Committee on Reports of Officers. All reports will be found on the pages indicated in the October 1953, Vol. 46, Number 10, JOURNAL of the Indiana State Medical Association. Supplemental reports and resolutions introduced before the House and referred to this committee are printed herewith.

EXECUTIVE SECRETARY (pages 1004-1005)

TREASURER (pages 1006-1008)

CHAIRMAN OF THE COUNCIL (pages 1008-1010)

COUNCILOR REPORTS (pages 1010-1017)

EXECUTIVE COMMITTEE (pages 1018-1020)

AUDITING COMMITTEE (page 1044)

EDITOR OF THE JOURNAL (page 1063).

TENTH COUNCILOR DISTRICT—

The District held two excellent meetings during 1953, both well attended. The Spring session was held May 20. This was a combined meeting of the Lake County Medical Society and the Tenth Medical District. No business was conducted at this meeting. The entire program was a trip to the Abbott Laboratories in North Chicago, Illinois, and a dinner program at the Edgewater Beach Hotel in Chicago. One hundred and fifteen doctors and wives attended this very enjoyable affair as guests of the Abbott company.

The fall meeting was held October 7 at Whiting and was presided over by Dr. Lee Hickman, president of the District society. The Indiana Academy of General Practice provided the program with funds furnished by the Wyeth Pharmaceutical Company and the Indiana Heart Foundation. Doctor Hickman opened the meeting at 4:00 p. m. with an introduction of Dr. Lester Bibler of Indianapolis representing the I. A. G. P., and Dr. Michael Shellhouse, the Lake County I. A. G. P. representative. Mr. L. E. Converse, director of physicians relations for the Indiana Blue Shield program, was present and was introduced.

Doctor Bibler presented Dr. E. Grey Dimond, Chairman of the Department of Medicine, University of Kansas, who spoke on the subject of "Cardiac Surgery." The meeting adjourned at 5:30 for dinner and resumed at 7:00 p. m.

Mrs. W. B. Matthews, President of the Indiana State Medical Association Auxiliary, was introduced and made a brief talk. Many members of the Woman's Auxiliary were present during dinner and at this point adjourned to a separate room for their own meeting to hear a talk on Channel 11, Educational Television.

Doctor Hickman conducted an election which resulted in naming the following officers for 1954:

Councilor, Tenth District—Dr. J. R. Doty, Gary.
 Alternate Councilor—Dr. J. P. Vye, Gary.
 President—Dr. Ralph Eades, Valparaiso.
 Secretary—Dr. Herbert C. Ashmore, Hebron.

A standing ovation was given Dr. Harry Howard of Hammond who shortly was to be installed as President of the Indiana State Medical Association.

Doctor Bibler made a brief talk on the activities of the I. A. G. P. and thanked the co-sponsors for their financial support of the I. A. G. P. "Road Shows."

Doctor Hickman then introduced Dr. R. J. Pieri, Professor of Obstetrics and Gynecology at New York University and Vice-Chairman of the International College of Surgeons, who presented an hour-long color and sound film on the subject of the use of obstetrical forceps. Dr. Pieri was roundly applauded for the excellence of the film which he had made himself.

Doctor Bibler then introduced Doctor Dimond

for the second time. His evening talk was on the relationship of medical schools to the private practitioner, and provoked considerable discussion of the problems, activities, and responsibilities of medical schools in their respective states and communities.

One hundred and twenty-five members attended this session.

J. ROBERT DOTY, M.D., *Councilor*.

REPORT OF THE REFERENCE COMMITTEE
ON REPORTS OF OFFICERS

Dr. Challman, chairman, presented the following report which was adopted:

Your committee has reviewed the reports of the Executive Secretary, Treasurer, Chairman of the Council, District Councilors, Executive Committee, Auditing Committee and Editor of the Journal, and recommends the acceptance of these reports as printed.

MATTERS REFERRED BY THE COUNCIL
TO THE HOUSE OF DELEGATES

DR. ELTON R. CLARKE, chairman of the Council, presented the following matters for consideration of the House of Delegates:

1. **Recommendation that delegates be instructed to contact Congressmen.** The Council suggested that delegates make an effort to contact their Congressmen and invite them to their society meetings to discuss legislation of interest to the profession.

2. **Recommendation that resolution on Cline report be adopted.** (Referred to Reference Committee on Medical Education and Hospitals. See report, page 1320).

3. **Resolution advocating adoption of proposed 23rd amendment.** (H. J. Res. 123). (Referred to Reference Committee on Public Policy and Legislation. See report, page 1322).

4. **Recommendation regarding issuance of temporary permits to practice medicine.** (Referred to Reference Committee on Medical Education and Hospitals. See report, page 1314).

5. **Resolution requesting establishment of permanent, continuing liaison committee with Indiana Department of Public Welfare.** (Referred to Reference Committee on Publicity. See report, page 1324).

6. **Amendments to the Bylaws, as follows:**

a. Clarification regarding apportionment of delegates to joint societies. Chapter IV, Section 2.

b. Receipt by headquarters office of resolutions to come before House of Delegates. Chapter IV, new section.

(Referred to Reference Committee on Amendments to Constitution and Bylaws. See report, page 1325).

7. **Recommendation that interim session be discontinued.** (Referred to Reference Committee on

Amendments to Constitution and Bylaws. (See report, page 1328).

8. **Recommendation that state association dues be reduced \$5.00.** (Referred to Reference Committee on Miscellaneous Business. See report, page 1331).

9. **Recommendations on hospital accreditation matters.** (Referred to Reference Committee on Medical Education and Hospitals. See report, page 1314).

MATTERS REFERRED TO REFERENCE COMMITTEE ON SECTIONS AND SECTION WORK

The following reports of standing and special committees were referred to the Reference Committee on Sections and Section Work. All reports will be found on the pages indicated in the October 1953, Vol. 46, Number 10, JOURNAL of the Indiana State Medical Association.

COMMITTEE ON SCIENTIFIC EXHIBITS

COMMITTEE ON SCIENTIFIC WORK

COMMITTEE ON INSTRUCTIONAL COURSES (page 1055)

COMMITTEE ON INDUSTRIAL HEALTH, Third paragraph (page 1024)

COMMITTEE ON CIVIL DEFENSE, Last paragraph (page 1049).

REPORT OF REFERENCE COMMITTEE ON SECTIONS AND SECTION WORK

DR. LESTER D. BIBLER, chairman, presented the following report, which was adopted:

The Reference Committee on Sections and Section Work met at 9:00 a. m., Monday, October 19, with all members present and wishes to submit the following report:

1. *Report of the Committee on Scientific Exhibits.* Since no written report was submitted, the report of this committee is based on an examination of the exhibits. The reference committee has examined the scientific exhibits and we wish to commend the Committee on Scientific Exhibits for its excellent work and untiring efforts to secure such a number of exhibits. This committee was headed by Dr. John L. Arbogast. We feel that the exhibits are well displayed, in an advantageous location.

We recommend the continued interest of the committee in securing more scientific exhibits at our state convention.

The scientific exhibitors are to be highly commended for the excellent displays presented.

2. *Report of Committee on Scientific Work.*

This reference committee wishes to congratulate Dr. Clyde G. Culbertson and his Committee on Scientific work for its outstanding program and arrangement of this program so that there is no apparent conflict between the meetings of the House of Delegates, the committee meetings, the general meetings, and the sectional meetings.

We wish to express our appreciation to the speakers for their time and efforts in presenting their excellent papers.

3. *Report of Committee on Instructional Courses.* The report of the Committee on Instructional Courses has been reviewed and we recommend that it be accepted. Dr. Seth W. Ellis and his committee are to be commended for the excellent program they have prepared.

4. *Third paragraph of report of Committee on Industrial Health.* The third paragraph of the report of the Committee on Industrial Health was reviewed and we recommend that some time be allotted to this subject on the general program.

5. *Last paragraph only of report of Committee on Civil Defense.* After consideration of the last paragraph of the report of the Committee on Civil Defense, your reference committee recommends that the creation of a Section on Civil Defense be delayed at this time.

In order to bring civil defense to more of the physicians of the State of Indiana, this committee recommends the following plan:

- (1) Sufficient time be allotted on the general program for the committee to arrange for instruction of all physicians as to their duties and obligations and to stimulate their interest and participation in medical civil defense.
- (2) A booth display be prepared and exhibited, to picture clearly the operational plan of medical civil defense in Indiana.

The chairman wishes to thank the members of the reference committee for their interest and cooperation in reviewing the above subjects.

MATTERS REFERRED TO THE REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

The following matters were referred to the Reference Committee on Medical Education and Hospitals. All reports will be found on the pages indicated in the October 1953, Vol. 46, Number 10, JOURNAL of the Indiana State Medical Association. Supplemental reports and resolutions introduced before the House and referred to this committee are printed herewith.

REPORT OF COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

(pages 1024-1026) and the following *Supplementary Report of the Committee*: presented by Dr. James W. Denny, chairman:

"Mr. Chairman, members of the Council, and guests:

"We now have sent \$87,000 to the American Medical Education Foundation, and have in our trust fund at the Fletcher Trust \$81,000 plus.

"We are starting our campaign in earnest on November 1, 1953, and expect to reach our goal of \$50,000 for the year 1953. This campaign will be conducted in three ways: from A. M. A. level by literature and pledge cards mailed from the A. M. A.; from our state committee by three letters with pledge cards, as in the past; and by committees at county level, these committees having already been appointed.

"In addition, the Woman's Auxiliary is entering the field, and I believe they will render good help.

"We have the first two programs for telephone seminars organized, but we are finding the going is tough. The county societies are using the tape recordings more and more, and dispensing with the telephone. I believe they are right in doing so. We are going to continue to build our library of scientific recordings, and believe this will be of ever growing service.

"I again want to express my thanks to Jim Waggener and his staff for their help to our committee."

REPORT OF REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

DR. H. R. STIMSON, chairman, submitted the following report, which was adopted:

Your committee wishes to recommend the acceptance of the report of the Standing Committee on Medical Education and Hospitals. We also wish to commend the Standing Committee for its diligent work on telephone seminars, recording loan library, and Medical Education Foundation activities.

Your committee also wishes to recommend adoption of the supplementary report of the Medical Education and Hospitals Standing Committee as given by Dr. James Denny on the floor of the House of Delegates, October 18, 1953.

REPORT OF SUBCOMMITTEE ON PRECEPTORSHIPS (page 1042)**REPORT OF REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS**

DR. H. R. STIMSON, chairman, submitted the following report, which was adopted:

The committee recommends acceptance of the report of the Subcommittee on Preceptorships, which is published on page 165 of the Handbook (same as page 1042, Oct. JOURNAL), and recommends continuation of its activities.

RESOLUTION ON MEDICAL LICENSURE

The following resolution was introduced by Dr. James W. Denny as chairman of the Standing Committee on Medical Education and Hospitals, and was referred to the Reference Committee on Medical Education and Hospitals:

The Standing Committee on Medical Education and Hospitals of the Indiana State Medical Association recommends to the House of Delegates that the following be adopted as a statement of policy of this Association.

That the Board of Medical Registration and Examination adopt a rule or regulation through which temporary license may be granted to be valid until the next regular meeting of the Board, which is established by law as being the second Tuesday in January and July of each year. That all meetings except the January and July meetings be called by the board as special meetings. That they give examinations at such regular meetings under rules and regulations which would not require the full attendance of the board at the time the examinations are taken, but which would nevertheless keep all applicants upon a uniform basis for obtaining a license for the practice of medicine.

That a proper body of the Indiana State Medical Association confer with the Board of Medical Registration and Examination, and the proper legal authorities regarding this matter.

Adopted by the Standing Committee on Medical Education and Hospitals at its regular meeting of September 27th, 1953.

RECOMMENDATION OF COUNCIL ON TEMPORARY MEDICAL LICENSURE

DR. ELTON R. CLARKE, chairman of the Council, presented the following suggestions from the Council, which were referred to the Reference Committee on Medical Education and Hospitals:

SUGGESTED RULES

That there shall be two regular meetings of the Board each year, one on the second Tuesday in January and one the second Tuesday in July. Special meetings shall be on the call of the Chair-

man and only business referred to in the notice may be considered at such special meetings.

The Secretary of the Board is authorized to issue a temporary permit to practice medicine to an applicant therefor who has filed an application to take the next available examination for a certificate for an unlimited license to practice medicine, with the fee of \$25.00, if such applicant furnishes satisfactory proof that he has the requisite qualifications, under the law and regulations, to take such examination and is not eligible to a certificate by reciprocity. No more than two successive temporary permits shall be issued to the same person. A person filing a second application, who has previously filed an application to take such examination and paid a fee of \$25.00, but who has not taken such examination, shall not be required to pay an additional fee with the second application.

REPORT OF REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

DR. H. R. STIMSON, chairman, presented the following report, which was adopted:

Temporary Medical Licensure

Your Committee first considered the resolution approved by the Council regarding the issuance of temporary permits to practice medicine by the Indiana State Board of Medical Registration. This resolution was presented as a substitute for the resolution appearing on page 86 of the Handbook, and reads as follows:

"Suggested Rules

"There shall be two regular meetings of the Board each year, one on the second Tuesday in January and one the second Tuesday in July. Special meetings shall be on the call of the Chairman and only business referred to in the notice may be considered at such special meetings.

"The Secretary of the Board is authorized to issue a temporary permit to practice medicine to an applicant therefor who has filed an application to take the next available examination for a certificate for an unlimited license to practice medicine, with the fee of \$25.00, if such applicant furnishes satisfactory proof that he has the prerequisite qualifications, under the law and regulations, to take such examination and is not eligible to a certificate by reciprocity. No more than two successive temporary permits shall be issued to the same person. A person filing a second application, who has previously filed an application to take such examination and paid a fee of \$25.00, but who has not taken such examination, shall

not be required to pay an additional fee with the second application."

We recommend the following amendment to the above:

"RESOLVED that a committee be appointed by the President to meet with the Indiana State Board of Medical Registration and Examination to formulate means, either by a Board ruling, or by other legal means, by which a temporary permit or permits may be issued to those applicants for licensure who meet the requirements of the Board, but who are unable to obtain licensure by endorsement or reciprocity, pending the opportunity to be examined by the Indiana State Board of Medical Registration and Examination."

RESOLUTION ON ACCREDITATION OF HOSPITALS

The following resolution was introduced by Dr. James W. Denny as chairman of the Standing Committee on Medical Education and Hospitals and was referred to the Reference Committee on Medical Education and Hospitals:

WHEREAS, The Accrediting Standards promulgated by the new Joint Commission on Accreditation of Hospitals have been published, and

WHEREAS, The wording of the standards leave doubt in the minds of many individual physicians, indicating there is need for a clear definition to avoid misinterpretation and misunderstanding, and

WHEREAS, Our interpretation of Contingent II-A-7 leads us to believe the requirement for meeting attendance by individual members of a department or departments will prove a burden and will require time of the physician that might be better devoted to patient care, and

WHEREAS, Our interpretation of Contingent II-B-3, leads us to believe that this requirement not only will serve to raise the cost of medical care, but many times will work a hardship on the patient, and

WHEREAS, Our interpretation of Contingent II-E-1 and 2 leads us to believe that the General Practitioners will have no part in caring for their patients in accredited hospitals, unless they qualify for admission in other departments, and

WHEREAS, The medical profession generally has advocated the establishment of General Practice departments and residencies in our modern hospital training programs, and it appears the new standards of accreditation will thwart this effort, and

WHEREAS, Our parent organization, the American Medical Association apparently has no voice in the promulgation of rules and regulations of

this new commission, or have failed to counsel their representatives on rules and regulations to be adopted prior to adoption to ascertain they are not discriminatory of any branch of medicine, and

THEREFORE BE IT RESOLVED, That the House of Delegates of the Indiana State Medical Association take the following action:

1. That the AMA and the Joint Commission be requested to supply a clear-cut interpretation of Contingents II-A-7; II-B-3 and II-E-1 and 2, together with a clear-cut outline of the enforcement policy of the commission and that this be sent to all component State and County Medical Associations and Societies.
2. That staff membership attendance requirements be further reduced so a General Practitioner, or any other physician, who might become affiliated with more than one department will not be required to attend 75% of all meetings of each department plus the CP Conferences.
3. That the Department of General Practice include a clinical service.
4. That the American Medical Association carefully review all proposed regulations and enforcement policies of the Joint Commission before same are placed into operation. That such rules, regulation and enforcement policies be solely in the interest of better patient care and that they are not discriminatory against any branch of medicine, and

BE IT FURTHER RESOLVED, That a copy of this resolution be forwarded to the House of Delegates of the American Medical Association for consideration by that body at its next meeting.

Adopted by the Standing Committee on Medical Education and Hospitals at its meeting on September 27th, 1953 for presentation to the House of Delegates of the Indiana State Medical Association.

RESOLUTION DEALING WITH MULTIPLICITY OF MEETINGS REQUIRED OF GENERAL PRACTITIONERS

The following resolution was introduced on behalf of the Indianapolis Medical Society by Dr. James W. Denny, chairman of the Marion County Delegation, and was referred to the Reference Committee on Medical Education and Hospitals:

WHEREAS, correspondence with the executive director of the Joint Commission on Accreditation of Hospitals has definitely established that the Commission expects GPs to attend monthly departmental meetings of all departments in which he has privileges, and

WHEREAS, many directives of the Joint Commission are not clearly stated and may be interpreted in several ways; thus resulting in confusion and misunderstanding, now, therefore

BE IT RESOLVED, that the proposed regulation for GP departments in Hospitals of the Joint Commission be modified to set forth that attendance of a member of a GP section at monthly meetings of the department of GP shall be the only attendance at department meetings which the general practitioner shall be required to have, plus the same requirements for attendance at general staff meetings as all other members of the active hospital staff, and

BE IT FURTHER RESOLVED, that this, as well as other regulations, issued by the Joint Commission are too vague and should either be clarified by the Commission in its directives or the right be given to each self-governing staff to add clarifying details, and

BE IT FURTHER RESOLVED, that a copy of this resolution be forwarded to the delegates of this Society to the State House of Delegates with instructions that they work for its adoption at the annual meeting of the Indiana State Medical Association in French Lick, Indiana, October 18-21, 1953, and if adopted there that Indiana's delegates to the AMA be instructed to work for its adoption at the AMA clinical session in St. Louis in December, 1953, and

BE IT FURTHER RESOLVED, that if this resolution is adopted by the State House of Delegates that copies, with explanatory letter, be sent to all state and territorial component associations of the AMA, with the request that they seek adoption of it in their local areas.

RESOLUTION DEALING WITH CLINICAL PRIVILEGES OF GENERAL PRACTITIONERS IN HOSPITALS

The following resolution was introduced on behalf of the Indianapolis Medical Society by Dr. James W. Denny, chairman of the Marion County Delegation and was referred to the Reference Committee on Medical Education and Hospitals:

WHEREAS, The Joint Commission on Accreditation of Hospitals has issued a specific directive labeled section B-2-e for general practice departments of hospitals wherein a department of general practice shall be an organized segment of the medical staff comparable to that of other staff departments but with certain limitations, including limitation of the responsibility of this department to administration and education; definitely prohibiting this department from being a clinical service or any patients being admitted to the

department as such, with the exception of responsibility for conducting the out-patient department in whole or in part if such department exists; and

WHEREAS, This ruling does not grant the general practitioner basic professional privileges except as an adjunct member in other clinical departments, now, therefore;

BE IT RESOLVED, That this regulation be amended to extend basic professional and clinical privileges to general practitioners, without adjunct memberships, to all members of such general practice department automatically at the time his application for staff membership is approved to include the right to engage, in the hospital, in: general diagnosis and therapy, pediatrics, obstetrics in uncomplicated cases, uncomplicated fractures, minor surgery, and such other surgery or other procedures as the training and experience of the individual practitioner shall warrant as determined by the credentials committee; and

BE IT FURTHER RESOLVED, That a copy of this resolution be forwarded to the delegates of this Society to the State House of Delegates with instructions that they work for its adoption at the annual meeting of the Indiana State Medical Association in French Lick, Indiana, October 18-21, 1953, and if adopted there that Indiana's delegates to the AMA be instructed to work for its adoption at the AMA clinical session in St. Louis in December 1953, and

BE IT FURTHER RESOLVED, That if this resolution is adopted by the State House of Delegates that copies, with explanatory letter be sent to all state and territorial component associations of the AMA, with the request that they seek adoption of it in their local areas.

RESOLUTION ON JOINT COMMISSION ON HOSPITAL ACCREDITATION

The following resolution was introduced by Dr. J. William Wright, Indianapolis, and was referred to the Reference Committee on Medical Education and Hospitals:

WHEREAS, The overwhelming majority of doctors in these United States are conscientious, sincere, competent physicians who place the welfare of their patients above all else.

WHEREAS, Physicians in a given local community are the best judges of what hospital staff requirements are necessary for the welfare of patients in that community.

WHEREAS, Any administrative body further removed from the local community than the State Medical Association cannot be reasonably expected to know the required medical needs of a local community.

THEN BE IT RESOLVED THAT, Only those decisions of the Joint Commission on Hospital Accreditation be deemed applicable to any hospital staff in a given community that are ratified by a favorable majority of a quorum of the members of the Medical Society of that State.

BE IT FURTHER RESOLVED, that the phrase "those decisions" as used above be taken to mean those hospital staff requirements which are already a part of the Joint Commission on Hospital Accreditation or any additional requirements which may be made a part of this program.

BE IT FURTHER RESOLVED, that if this resolution is acted upon favorably by this House of Delegates of the Indiana State Medical Association, copies of this resolution be forwarded to the state medical societies of the remaining forty-seven states.

RESOLUTION TO HARMONIZE FUNCTIONS OF JOINT ACCREDITATION COMMISSION

The following resolution was introduced by Dr. A. G. Blazey, Washington, and was referred to the Reference Committee on Medical Education and Hospitals:

WHEREAS, the principle of coercion has always interfered with the natural laws of creative initiative and increased productivity; and,

WHEREAS, the measures used by the Joint Commission on Hospital Accreditation (J.C.H.A.) do not properly take into consideration problems of a local nature, and might therefore do more harm than good; and,

WHEREAS, the J.C.H.A. has already stated that "It is desirable that means should be provided at local, state and national levels for review of problems of individual hospital-physicians relationship by organized medical and hospital groups"; now, therefore,

BE IT RESOLVED, that measures for the improvement of medical care in any hospital be specified as recommendations from the J.C.H.A. to be approved by a majority vote of that hospital's active medical staff; and,

BE IT RESOLVED, that in the event of differences of opinion which cannot be arbitrated between a hospital staff and the J.C.H.A., the matter shall be presented to the local medical society to which the staff members belong for a majority vote decision; and,

BE IT RESOLVED, that if successful arbitration and action for all parties concerned is not obtained at local society level, the matter be referred to their state medical association for a majority vote of its house of delegates, whose decision shall be final; and,

BE IT FURTHER RESOLVED, that this resolution be submitted to all state medical associations, and to the next interim session of the AMA House of Delegates, as a means of safeguarding the future health of all patients hospitalized in the United States, and to act as a check on the unlimited powers of the J.C.H.A.

RESOLUTION ADOPTED BY THE MIAMI COUNTY MEDICAL SOCIETY ON ACCREDITATION OF HOSPITALS

DR. D. W. FERRARA, Peru, introduced the following resolution, which was referred to the Reference Committee on Medical Education and Hospitals:

BE IT RESOLVED by the Miami County Medical Society that they are opposed to the accreditation of hospitals by the present national organization.

BE IT FURTHER RESOLVED that the Indiana State Medical Association name a committee who shall draw up requirements to be met by the various county societies, said requirements should not be so strict as to work a hardship on any county.

BE IT FURTHER RESOLVED that a copy of this resolution be forwarded to the delegate and the alternate delegate of this society, to the state House of Delegates with instructions that they work for adoption of its principles at the annual meeting of the Indiana State Medical Association at French Lick, Indiana, October 18 to 21, 1953, and that a copy be forwarded to the secretary of the Indiana State Medical Association.

RESOLUTION FROM HOWARD COUNTY MEDICAL SOCIETY ON CLINICAL PRIVILEGES OF GENERAL PRACTITIONERS IN HOSPITALS

DR. RICHARD P. GOOD, Kokomo, introduced the following resolution, which was referred to the Reference Committee on Medical Education and Hospitals:

WHEREAS, the Joint Commission on Hospital Accreditation has issued a specific directive labeled "Section B-2-e" for General Practice Departments of general Hospitals wherein a Department of General Practice shall be an organized segment of the Medical Staff comparable to that of other Staff departments but with certain limitations, including limitation of the responsibility of this department to administration and education; definitely prohibiting this department from being a clinical service or any patients being admitted to that department as such, with the exception of responsibility for conducting an out-patient department in whole or part; calling for members of the Department of General Practice who will not have a separate service to be given privileges in the clinical services of other departments in accordance with their experience and training on the recommendation of the credentials committee; and further making such a member of the General Practice Department subject to the rules of the service on which he shall have been granted a privilege, and subject to the jurisdiction of the Chief of that clinical service involved, and,

WHEREAS, it is an obvious fact that general practitioners throughout the country are in many places being discriminated against in hospital privileges, now

BE IT RESOLVED that, after all facts available have been studied, it is our opinion that the proposed regulation for General Practice Departments

in Hospitals of the Joint Commission on Hospital Accreditation should be modified to set forth that attendance of a member of a General Practice Department at monthly meetings of the Department of General Practice shall be the only attendance at Department meetings which this general practitioner shall be required to have, plus the same requirements for attendance at General Staff meetings as all other members of the active Hospital Staff, and

BE IT FURTHER RESOLVED that we believe this regulation should be amended to extend basic professional and clinical privileges to general practitioners, without adjunct memberships, to all members of such a General Practice Department automatically at the time his application for Staff membership is approved to include the right to engage in the hospital in general diagnosis and therapy, obstetrics in uncomplicated cases, uncomplicated fractures, minor surgery, and such other surgery or other procedures as the training and experience of the individual practitioner shall warrant as determined by the Credentials Committee.

COUNCIL RECOMMENDATIONS ON HOSPITAL ACCREDITATION MATTERS

DR. ELTON R. CLARKE, chairman of the Council, presented the following recommendations, which were referred to the Reference Committee on Medical Education and Hospitals:

1. Council considered the two resolutions on page 86 and page 88 of the Handbook—one dealing with multiplicity of meetings required of general practitioners, and the other dealing with clinical privileges of general practitioners in hospitals, which were adopted by the Indianapolis Medical Society, and recommends approval of these resolutions by the House of Delegates.

2. Council passed a motion that the above resolution be amended to include omitting mandatory consultations, except where required by law or rules of hospital.

3. Council approved adoption of paragraph 3 of the resolution on accreditation, as introduced by the Standing Committee on Medical Education and Hospitals. Page 85, Handbook.

4. Council approved National level accreditation.

5. Council approved aims of the Joint Accreditation Commission and appreciation of the tremendous work done by that Commission.

6. Council approved close liaison be established between the Indiana State Medical Association and the National Joint Commission on Accreditation for mutual help and coordination. That this co-operation be handled through our standing state Committee on Medical Education and Hospitals. To avoid being an ineffectual minority, that this entire problem be studied with the aim of determining the attitude of other state organizations.

REPORT OF REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

DR. H. R. STIMSON, chairman, presented the following report and moved its adoption. Motion seconded by Dr. William C. Reed.

RESOLUTIONS CONCERNING JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, AND ITS RELATION TO HOSPITALS AND DOCTORS

Your Committee has carefully studied the following resolutions presented to this House of Delegates:

The resolutions appearing on pages 84, 86 and 88 of the Handbook; the resolutions introduced by Dr. William Wright and Dr. Arthur Blazey; and the resolutions introduced by Miami County and by Howard County. Your committee has also carefully studied the recommendations passed by the Council on October 18, 1953, concerning all matters of hospital accreditation. We have given careful consideration to all the evidence given in open meetings held by the Committee on October 19, 1953, and to consultation with the American Medical Association officials in Chicago on October 19, 1953.

The Committee now recommends the following resolution:

WHEREAS, the Accrediting Standards promulgated by the new Joint Commission on Accreditation of Hospitals have been published, and

WHEREAS, the wording of the Standards leave doubt in the minds of many individual physicians, indicating there is a need for a clear definition to avoid misinterpretation and misunderstanding, and

WHEREAS, our interpretation of II-A-7 (which reads as follows:

"7. Staff Meetings

"The sole objective of staff meetings is improvement in the care and treatment of patients in the hospital. Unless such objectives are met fully by the program set forth below (Contingent, II, A4), monthly meetings of the staff, not less than twelve in each calendar year, are required.

"Active staff attendance shall average at each meeting at least 75% of the active staff who are not excused by the Executive Committee for exceptional conditions such as sickness or absence from the community.

"Each active staff member shall attend 75% of staff meetings unless excused by the Executive Committee for exceptional conditions such as sickness or absence from the community.

"In addition to matters of organization, the programs of such meetings must include a report of the Executive Committee and be limited largely to the review of current or recent cases in the hospital. Scientific programs not associated with the work of the hospital do not meet this requirement.")

leads us to believe the requirement for meeting attendance by individual members of a department or departments will prove a burden and will require

time of the physician that might be better devoted to patient care, and

WHEREAS, our interpretation of II-B-3 (and I shall read that:

"3. Consultations

"Except in emergency, consultation with a member of the Consulting or of the Active medical staff shall be required in all major cases in which the patient is not a good risk and in all caesarean sections, sterilizations, curettages, or other operations which may interrupt a known, suspected, or possible pregnancy. The consultant shall make and sign a record of his findings and recommendations in every such case. In all cases where a rule of the hospital requires consultation and in the case of free patients, the consultant shall give his services without charge.")

leads us to believe that this requirement not only will serve to raise the cost of medical care, but many times will work a hardship on the patient, and

WHEREAS, Our interpretation of Contingent II-E-1 and 2 (which reads:

"E. General Practice Department

"A Department of General Practice shall be an organized segment of the medical staff comparable to that of other staff departments with the following limitations:

"1. The responsibilities of this department shall be limited to administration and education. It shall not be a clinical service and no patients shall be admitted to the department. If and when desirable, however, the department may be made responsible for conducting the outpatient clinic in whole or in part.

"2. Since the Department of General Practice will not have a separate service, the members of the General Practice Department shall have privileges in the clinical services of the other departments in accord with their experience and training, on recommendation of the Credentials Committee. In any service in which any general practitioner shall have privilege, he shall be subject to the rules of that service and subject to the jurisdiction of the chief of the clinical service involved.")

leads us to believe that the General Practitioners will have no part in caring for their patients in accredited hospitals, unless they qualify for admission in other departments, and

WHEREAS, the medical profession generally has advocated the establishment of General Practice departments and residencies in our modern hospital training programs, and it appears the new standards of accreditation might thwart this effort, and

WHEREAS, your Reference Committee has carefully studied the prerequisites to accreditation by the Joint Commission on Accreditation of Hospitals, and has concluded that the Joint Commission recognizes that the medical functions of the hospital must be delegated to the medical staff, as outlined under "Standards Required I-B, (which reads:

"B. Governing Body

"All phases of the conduct of the hospital are the legal and moral responsibility of the governing body. In the discharge of its duties, the governing body is responsible to the patient, the community, and the sponsoring organization. Since governing bodies are rare-

ly qualified medically, responsibility for the medical functions of the hospital must be delegated to the medical staff.

"For effective action, the governing body shall:

- "1. adopt by laws in accordance with legal requirements;
- "2. meet at stated intervals;
- "3. appoint committees, with an Executive Committee and a Joint Conference Committee as a minimum;
- "4. appoint members of the medical staff (see REQUIRED II, A3);
- "5. appoint a qualified hospital administrator for a specified term.)"

and

WHEREAS, the overwhelming majority of doctors in the United States are conscientious, sincere, competent physicians who place the welfare of their patients above all else, and

WHEREAS, Physicians in a given local community are cognizant of what hospital staff requirements are necessary for the welfare of patients in that community, and we believe the physicians in that community should have a voice in the regulation of medical affairs in their community,

NOW THEREFORE BE IT RESOLVED, That the House of Delegates of the Indiana State Medical Association go on record as approving the Joint Commission on Accreditation of Hospitals as the official body for hospital accreditation, and approve the aims and principles of the Joint Accreditation Commission, and expresses appreciation of the tremendous work done by that body, and

BE IT FURTHER RESOLVED, That Section II-B-3 (which was read above) be changed to omit mandatory consultations except where required by state law or by the rules of the hospital, and

BE IT FURTHER RESOLVED, That the department of general practice may include a clinical service, and

BE IT FURTHER RESOLVED, That the House of Delegates recommend that closer liaison be established between the Indiana State Medical Association and the national Joint Accreditation Commission for mutual help and coordination, and that this liaison be established through the Standing Committee on Medical Education and Hospitals of the Indiana State Medical Association, and

BE IT FURTHER RESOLVED, That to avoid being an ineffectual minority, it is recommended that this entire problem be studied with the aim of determining the attitude of other state medical associations, and

BE IT FURTHER RESOLVED, That a copy of this complete resolution be sent to the Council on Medical Education and Hospitals of the American Medical Association, and the Joint Commission on Accreditation of Hospitals.

Your Reference Committee wishes to express its appreciation to all members of the Association for their constructive criticism and advice before the open meetings concerning this most difficult problem.

* * * * *

DR. A. G. BLAZEY moved adoption of the following amendment to the report of the Reference Com-

mittee on Medical Education and Hospitals, and the amendment was adopted on a standing vote:

"That the Indiana delegates to the interim session of the House of Delegates of the American Medical Association meeting in St. Louis, December 1 to December 4, 1953, be instructed to introduce at that session a resolution which will provide a means of check and control of the rules of the Joint Commission on Accreditation of Hospitals."

* * * * *

DR. STIMSON's motion that this section of the report of the Reference Committee on Medical Education and Hospitals be adopted, as amended, was duly seconded, and carried.

RESOLUTION ON CLINE REPORT

The following resolution was introduced by Dr. James W. Denny as chairman of the standing Committee on Medical Education and Hospitals, and was referred to the Reference Committee on Medical Education and Hospitals:

WHEREAS, The American Medical Association appointed a competent committee composed of Drs. John Cline, past president; E. Vincent Askey, vice-speaker; F. J. L. Blasingame and Edwin S. Hamilton, members of the Board of Trustees and Arch Walls, who have made an exhaustive study of the relationship between Osteopathy and Medicine, and

WHEREAS, This report was compiled only after a survey of opinion was made in each component state Association, and

WHEREAS, The report was made to the House of Delegates of the American Medical Association at their annual meeting in New York on June 1, 1953, and

WHEREAS, The report met with apparent favor with the delegates there assembled, but ordered that the report be studied by the various states, before final action is taken at the annual meeting of the American Medical Association in 1954, and

WHEREAS, Each component county medical society, through its duly elected delegate, and each Councilor District through its duly elected Councilor, has received a verbatim copy of the report as presented by Doctor Cline's committee, for their own consideration and study, said copy being received well in advance of this meeting.

NOW THEREFORE BE IT RESOLVED, That the Indiana State Medical Association, as a component part of the American Medical Association, concur in and approve the Cline report as submitted, and

BE IT FURTHER RESOLVED, That the Delegates to the American Medical Association, from Indiana, be and are hereby instructed to express the approval of this said report, by their vote when the matter comes up for decision by the House of Delegates of the American Medical Association.

REPORT OF REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

DR. H. R. STIMSON, chairman, presented the following report, which was adopted:

RESOLUTION ON THE CLINE REPORT

WHEREAS, on page 433 of The Journal of the American Medical Association, vol. 152, No. 5, it states, "Under an amendment to the medical practice act in 1945, osteopaths in Indiana are permitted to practice medicine and surgery. Persons who were licensed in osteopathy before 1945 are authorized to practice osteopathy, surgery and obstetrics." and,

WHEREAS, in the State of Indiana, graduates of osteopathic schools are required to pass the same examination as graduates of medical schools,

NOW, THEREFORE BE IT RESOLVED, that the resolution on the Cline Report be approved in principle, and

BE IT FURTHER RESOLVED, that *modern* osteopathy as defined above in The Journal of the American Medical Association, not be classified as cultist healing in Indiana. While the State of Indiana is not the home of any school of osteopathy, it is the feeling of this Reference Committee that all schools of osteopathy should be open for inspection and approval by the Council on Medical Education and Hospitals of the American Medical Association, and

BE IT FURTHER RESOLVED, that since the objectives of the American Medical Association include improvement in undergraduate and postgraduate education, Doctors of Medicine should teach in osteopathic schools, and

BE IT FURTHER RESOLVED that for the time being the relationship of Doctors of Medicine to Doctors of Osteopathy should be a matter for determination by the several state medical associations.

MATTERS REFERRED TO THE REFERENCE COMMITTEE ON PUBLIC POLICY AND LEGISLATION

The following matters were referred to the Reference Committee on Public Policy and Legislation. All reports will be found on the pages indicated in the October 1953, Vol. 46, Number 10, JOURNAL of the Indiana State Medical Association. Supplemental reports and resolutions introduced before the House and referred to this committee are printed herewith.

REPORT OF COMMITTEE ON PUBLIC POLICY AND LEGISLATION (pages 1026-1027)

REPORT OF COMMITTEE ON PUBLIC RELATIONS (pages 1028-1034)

REPORT OF BOARD OF APPEALS ON PHYSICIAN-PATIENT RELATIONS (pages 1020-1021)

REPORT OF ALCOHOLICS STUDY COMMITTEE (pages 1042-1043)

REPORT OF COMMITTEE ON CRIPPLED CHILDREN SERVICES (page 1052)

REPORT OF COMMITTEE ON RURAL HEALTH (pages 1035-1041)

REPORT OF COMMITTEE ON MATERNAL AND CHILD HEALTH (page 1056) and supplementary report presented by Dr. A. W. Cavins, chairman:

SUPPLEMENTARY REPORT OF COMMITTEE ON MATERNAL AND CHILD HEALTH INDIANA STATE MEDICAL ASSOCIATION

Since the report published in THE JOURNAL by this Committee, a meeting was held October 4, 1953, at Indianapolis, at which time several matters pending were disposed of. The chief of these were as follows:

In regard to the Brown County Maternity Service, it was the opinion of the Committee that upon the retirement of the present nurse-midwife, or at the time of her departure from the Service, the Service be discontinued, unless cause could be shown at that time for the necessity of the continuation of the Brown County Maternity Service.

The matter of prophylaxis for ophthalmia neonatorum was discussed because certain hospitals in Indiana have indicated a desire to conduct research projects concerning the method of prophylaxis. It was noted that the Committee had, in joint meeting with the Committee on Conservation of Vision, taken this matter up in 1948, and at that time the final decision was that "the Crede method be continued as it has in the past until more proven acceptable methods are developed." At the October 4, 1953 meeting, the following motion was passed: The Committee on Maternal and Child Health of the Indiana State Medical Association does not favor change of the regulation for prophylaxis for ophthalmia neonatorum at the present time, provided that the Indiana State Board of Health, with the approval of the Committee on Conservation of Vision of the Indiana State Medical Association, may grant permission for specific research problems, to vary the procedure for the prophylaxis of ophthalmia neonatorum, for a period of one year. A report of this research work is to be sent to the Indiana State Board of Health, the Maternal and Child Health Committee, and the Committee on Conservation of Vision of the Indiana State Medical Association for approval at the end of said year.

The Committee decided that the Cesarean section study for all hospitals in the state of Indiana is a worthwhile project, and it was recommended that this be made an annual study, to be published in the Journal of the State Medical Association each year. Charts prepared by the Division of Hospital and Institutional Services of the Indiana State Board of Health are submitted as part of this supplementary report. It is the hope of the Committee that these charts can be printed with the Cesarean section study in the Journal. It is also recommended that the article on Cesarean section study include the percentages for each hospital in the state for the years 1949 and 1950, and the statistics as well as the percentages for the years 1951 and 1952. The Committee also believes that fetal mortality rates should not be included in the Cesarean section study.

The Committee also recommends that a map of the Gordon Armstrong incubator loan centers in Indiana, and information relative thereto, be published in the Journal of the State Medical Association.

The Committee also recommended to the Board of Health that a study be made each five years of the mortality and incidence rates pertinent to maternal and child health, and that this study be published in the State Medical Association Journal once each five years.

A report was made on the Institutes regarding care of prematures held in Indiana during the past year, and the Committee feels that these Institutes are of definite value.

The matter of classes in instruction regarding obstetrical matters for parents was discussed at length, including content as to the curriculum, and the manner of conducting same, and the Committee decided that no recommendation should be made relative to such classes except that classes for parents in any community be subject to the approval of the local medical society.

REPORT OF REFERENCE COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Dr. E. L. FITZSIMMONS, chairman, presented the following report, which was adopted:

We recommend the approval of the report of the **Board of Appeals on Patient-Physician Relations**, as printed on page 122 of the Handbook.

The report of the **Committee on Public Policy and Legislation**, printed on page 133 of the Handbook, is approved, and we recommend its adoption.

Report of the **Committee on Public Relations**, page 136 of the Handbook. We recommend the adoption of this report and we also recommend that the Indiana State Medical Association publish the "Public Relations Manual" as it is printed

in the Handbook, for distribution to all members of the Indiana State Medical Association.

We recommend the adoption of the report of the **Committee on Rural Health**, as printed on page 155 of the Handbook.

The report of the **Committee on Alcoholic Study** is approved as printed on page 165 of the Handbook, and we recommend its adoption.

We recommend the adoption of the report of the **Committee on Crippled Children Services**, as printed on page 184 of the Handbook.

We approve the report of the **Committee on Maternal and Child Health**, as printed on page 194 of the Handbook, and also the supplemental report of this committee which was presented at the first meeting of the House of Delegates, and we recommend the adoption of these reports.

RESOLUTION ADVOCATING ADOPTION OF PROPOSED 23rd AMENDMENT

DR. ELTON R. CLARKE, chairman of the Council, introduced the following resolution which had been approved by the Council, and which was referred to the Reference Committee on Public Policy and Legislation:

(H. J. Res. 123)

WHEREAS, America is the product of a people's faith in Constitutional law designed to protect the property and enterprises of each citizen from political invasion or conquest, and

WHEREAS, Many proposals coming before Congress, will, if adopted by a mere majority, further jeopardize the rights of the American people to their individual property and enterprises, and

WHEREAS, The intent and purpose of the Tenth Amendment to the Constitution was to prohibit governmental exercise of powers not specifically delegated to it, now,

THEREFORE, BE IT RESOLVED, that we, the delegates of the Indiana State Medical Association in regular session assembled this 18th day of October, 1953, exercise our Constitutional power to petition our Congress to preserve the intent and purposes of the Constitution by initiating an amendment to the Constitution, for submission to the people of the various States, to provide that:

The government of the United States shall not engage in any business, professional, commercial, financial or industrial enterprise except as specified in the Constitution.

BE IT FURTHER RESOLVED, that a copy of this Resolution be spread upon the minutes of this meeting, and that copies of it be sent to the President of the United States, and members of both Houses of Congress from his State.

REPORT OF REFERENCE COMMITTEE ON PUBLIC POLICY AND LEGISLATION

DR. E. L. FITZSIMMONS, chairman, submitted the following report, which was adopted:

Your committee approves the resolution advocating adoption of the proposed 23rd amendment (H. J. Res. 123), and we recommend its adoption.

RESOLUTION FROM COMMITTEE ON CONSERVATION OF VISION

The following resolution from the standing Committee on Conservation of Vision was referred to the Reference Committee on Public Policy and Legislation:

The Conservation of Vision Committee has had it called to their attention that optical houses of questionable reputation are soliciting M.D.'s to do their work instead of optometrists. Optometrists have obtained legislation which prevents solicitation of this type and their ranks. We feel that the medical society should obtain similar legislation.

Carl J. Rudolph, M.D., *Chairman.*

REPORT OF REFERENCE COMMITTEE ON PUBLIC POLICY AND LEGISLATION

DR. E. L. FITZSIMMONS, chairman, presented the following report, which was adopted:

Resolution from the Committee on Conservation of Vision.

Although we approve the principle expressed in this resolution, we feel that the resolution as written is too indefinite and we must recommend disapproval and that it be referred back to the Committee on Conservation of Vision for clarification.

RESOLUTION CONCERNING COMPULSORY SOCIAL SECURITY FOR DIFFERENT PROFESSIONAL GROUPS

DR. F. R. NICHOLAS CARTER, South Bend, introduced the following resolution which was referred to the Reference Committee on Public Policy and Legislation:

WHEREAS, several bills have been introduced both in the United States House and in the United States Senate advocating an extension of Social Security to many self-employed professional people, and

WHEREAS, extension of the present Social Security program will affect 10.5 million professional people, including doctors, lawyers, accountants, dentists, architects, self-employed farm operators, and hired farm workers, and a large number of household workers not now covered, and

WHEREAS, this program is a compulsory program, requiring that a certain stated amount of the income of this professional group, which includes doctors, be set aside to pay Social Security benefits after the age of sixty-five years, and

WHEREAS, doctors as a group do not retire from

the active practice of medicine at the age of sixty-five, and

WHEREAS, it is most uncommon for an individual doctor ever to retire from the active practice of medicine, usually preferring to take care of many of his old patients until the day of his death, and

WHEREAS, Social Security benefits become available at the age of sixty-five years, and

WHEREAS, the present law provides that such Social Security Benefits cannot be paid to a doctor or any other in this group who makes more than \$75.00 per month in the field from which his Social Security benefits arise, and

WHEREAS, a doctor in the latter years of his life, in all probability, will make more than \$75.00 per month in his gradually diminishing practice, and

WHEREAS, this will make any doctor who makes more than \$75.00 per month in his practice ineligible to secure Social Security benefits, according to the provisions of the law as now written,

NOW THEREFORE BE IT RESOLVED that the Indiana State Medical Association hereby expresses its disapproval of the extension of the present Social Security program to include physicians, for the reasons stated above.

BE IT FURTHER RESOLVED that this resolution be read to the Indiana State Medical Association in order that the State Association be instructed to acquaint all of the local medical societies with the danger of the proposed extension of the Social Security program, and

BE IT FURTHER RESOLVED that each local society be instructed to contact their different Congressmen and Senators and express their disapproval of the proposed legislation, and

BE IT FURTHER RESOLVED that the State Medical Association contact all of our Congressmen and the two State Senators and express its disapproval of the extension of Social Security benefits to the different professional groups as proposed.

SO BE IT RESOLVED.

REPORT OF REFERENCE COMMITTEE ON PUBLIC POLICY AND LEGISLATION

DR. E. L. FITZSIMMONS, chairman, presented the following report, which was adopted:

We recommend the adoption of the resolution which opposed compulsory social security for different professional groups.

RESOLUTION CONCERNING THE BUILDING OF A PENSION RETIREMENT PLAN FOR PHYSICIANS

DR. F. R. NICHOLAS CARTER, South Bend, introduced the following resolution: which was referred to the Reference Committee on Public Policy and Legislation:

WHEREAS, in recent sessions of Congress, certain bills have been introduced, the purpose of which was to provide pension retirement for physicians and other professional people such as lawyers, engineers, etc., and

WHEREAS, these bills provide that self-employed individuals be allowed to build up pension funds

by investing a portion of their current income, free of Federal income tax, and

WHEREAS, this would make it possible for physicians, lawyers, engineers, and all other self-employed persons, to set aside a limited amount of their income in specified investments, and pay income taxes on this amount only when it is withdrawn from savings at a later date, and

WHEREAS, these bills provide that limited amounts of a relatively high income, obtained during the years of greatest activity of doctors, engineers, etc., be exempted from the higher brackets of tax and would fall into lower brackets later when incomes of old age and retirement are smaller, and

WHEREAS, this is not a special privilege being granted to a professional group but merely a means of correcting an inequity in the income tax laws, and

WHEREAS, already employed persons at the present time have their pension funds with tax exempt contributions, and

WHEREAS, the period of training of all professional people is long, during which time there is expenditure of great amounts of money with no income, and

WHEREAS, this long period of training makes the period of actual productivity short, during which time a relatively high income is enjoyed, and

WHEREAS, present income tax schedules take a large percentage of the income during peak earning years and make it difficult to achieve adequate savings for old age.

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association is wholeheartedly in favor of these bills which create pension retirement provisions for physicians, lawyers, engineers, etc. by allowing certain tax free investments during the productive years.

BE IT FURTHER RESOLVED that this resolution be read to the Indiana State Medical Association and that this Association be instructed to contact all medical societies urgently requesting them to contact their Congressmen expressing their approval of the proposed plan to permit professional people to set aside a limited amount of their income for pension retirement.

SO BE IT RESOLVED.

REPORT OF REFERENCE COMMITTEE ON PUBLIC POLICY AND LEGISLATION

DR. E. L. FITZSIMMONS, chairman, submitted the following report, which was adopted:

We recommend the adoption of the resolution concerning the building of a pension retirement plan for physicians.

RESOLUTION OPPOSING S-1153, KNOWN AS THE "NATIONAL HEALTH ACT, 1953"

DR. G. B. WILDER, Anderson, introduced the following resolution which was referred to the Reference Committee on Public Policy and Legislation:

WHEREAS, Senator Ives of New York (for himself and Senator Flanders of Vermont) has introduced in the Senate of the United States S-1153 (known as the Ives Bill) which would provide for (1) assisting states in financing voluntary prepayment health service plans with subscription charges

based on subscribers' income; (2) encouraging establishment of local administrative health regions and districts; (3) enabling non-profit hospitals, medical schools, and nursing schools to maintain and improve their service facilities; (4) assisting voluntary prepayment plans to build and equip personal health service centers; (5) assisting medical education and (6) assisting local public health units, and

WHEREAS, enactment of S-1153 would mean actually federal subsidization of the voluntary plans, medical education and health facilities, and

WHEREAS, federal subsidization would bring about eventual centralized federal control with all of the deficiencies and blundering ineptitudes always prevalent in such federal control, and

WHEREAS, federal control would materially weaken the voluntary plans by encouraging actuarially unsound insurance practices and thus make them a vehicle for the complete socialization of medical care, and

WHEREAS, the voluntary plans have been enjoying a natural and healthy growth thus making it possible for more and more of the citizens to distribute the costs of their medical care through sound actuarial insurance experience, and

WHEREAS, financial assistance to the voluntary plans, to medical education, and to other health facilities is not and should never be the responsibility of a centralized federal government, and

WHEREAS, financing of the provisions of the Ives bill (S-1153) would require an annual amount of untold millions of dollars which would have to be supplied through taxes from Citizens already impoverished by existing needless and excessive taxation, and

WHEREAS, federal financial assistance to the voluntary plans would be an unfair and immoral act because it would constitute unfair competition to the commercial insurance industry which functions and serves under our system of free enterprise without federal financial assistance.

THEREFORE, BE IT RESOLVED that we, the members of the Indiana State Medical Association in regular session assembled this 18th day of October, 1953, do hereby unequivocally oppose S-1153 in its entirety.

BE IT FURTHER RESOLVED that the Legislative Committee of the Indiana State Medical Association be directed to utilize every legitimate force to defeat enactment of S-1153 and that each member of the Association be urged to express his views of disapproval of S-1153 to his Senators and Representatives in Congress; that the state and county medical societies be urged to act strongly against the measure and that the President of the United States and all members of Congress be informed of the Indiana State Medical Association's position of determined opposition to S-1153.

REPORT OF REFERENCE COMMITTEE ON PUBLIC POLICY AND LEGISLATION

DR. E. L. FITZSIMMONS, chairman, presented the following report, which was adopted:

We recommend adoption of the resolution opposing Senate Bill 1153, known as the "National Health Act of 1953." Your committee was unanimous in favoring this resolution.

MATTERS REFERRED TO THE REFERENCE COMMITTEE ON PUBLICITY

The following matters were referred to the Reference Committee on Publicity. All reports will be found on pages indicated in the October 1953, Vol. 46, Number 10, JOURNAL of the Indiana State Medical Association. Resolutions introduced before the House and referred to this committee are printed herewith.

REPORT OF COMMITTEE ON PUBLICITY
(pages 1034-1035)

REPORT OF COMMITTEE ON NECROLOGY
(page 1060)

REPORT OF COMMITTEE ON STATE FAIR
(page 1062)

REPORT OF COMMITTEE ON VETERANS AFFAIRS AND REHABILITATION (pages 210-212, Handbook)

REPORT OF REFERENCE COMMITTEE ON PUBLICITY

DR. HARRY P. ROSS, chairman, presented the following report, which was adopted:

Your Reference Committee on Publicity has reviewed the report of the *Committee on Publicity*, published on page 152 of the Handbook, and recommends the adoption of the report as printed.

The report of the *Committee on Necrology*, on page 200 of the Handbook, has been read, and the committee recommends the adoption of this report.

The report of the *Committee on State Fair* was reviewed and the committee recommends the adoption of this report as printed on page 206 of the Handbook.

The report of the *Committee on Veterans Affairs and Rehabilitation*, as printed on pages 210, 211 and 212, has been reviewed and the committee recommends the adoption of the report as printed and published in the Handbook.

RESOLUTION REQUESTING ESTABLISHMENT OF A PERMANENT CONTINUING LIAISON COMMITTEE WITH THE INDIANA DEPARTMENT OF PUBLIC WELFARE

DR. ELTON R. CLARKE, chairman of the Council, introduced the following resolution which had been approved by the Council, and which was referred to the Reference Committee on Publicity:

WHEREAS, The Indiana State Medical Association, through action of its House of Delegates, has created a temporary committee of liaison on medical matters with the State Department of Public Welfare, which committee has met with the State Department of Public Welfare and has requested that we invite the Indiana State Medical

Association to appoint a continuing liaison committee, and

WHEREAS, The State Department of Public Welfare has, since the adoption of Regulation 2-111 (e) (7), urged the appointment and use of advisory and technical committees representative of the health and community interests on a county level, and

WHEREAS, The majority of the counties in the State of Indiana have taken advantage of this regulation to create medical advisory committees to their county welfare boards, now

THEREFORE, BE IT RESOLVED, That because of the scope of the medical programs of public welfare in the State of Indiana, the State Board of Public Welfare hereby invites the Indiana State Medical Association to create a continuing liaison committee between that organization and the State Department of Public Welfare to advise and consult with it on the medical programs of the State Department of Public Welfare.

REPORT OF REFERENCE COMMITTEE ON PUBLICITY

DR. HARRY P. ROSS, chairman, presented the following report, which was adopted:

Consideration was given to the resolution requesting the establishment of a permanent continuing liaison committee with the Indiana Department of Public Welfare, as published on page 78, and which has been recommended by the Council in its deliberative session, and this committee recommends the adoption of the resolution as published on page 78 of the Handbook by this House of Delegates.

The committee wishes to commend all of the members of these various committees for their consideration, their timely activities and efforts, and we wish to recommend the adoption of this report of the reference committee in its entirety.

MATTERS REFERRED TO REFERENCE COMMITTEE ON HYGIENE AND PUBLIC HEALTH

The following reports of standing and special committees were referred to the Reference Committee on Hygiene and Public Health. All reports will be found on the pages indicated in the October 1953, Vol. 46, Number 10, JOURNAL of the Indiana State Medical Association.

COMMITTEE ON INDUSTRIAL HEALTH—entire report with exception of third paragraph, which was referred to Reference Committee on Sections and Section Work (pages 1022-1024)

COMMITTEE ON CANCER (page 1044)

COMMITTEE ON CHRONIC ILLNESS (pages 1045-1046)

COMMITTEE ON CONSERVATION OF VISION (pages 1049-1051)

COMMITTEE ON DIABETES (page 1052)

COMMITTEE ON FOOT HYGIENE—No written report.

COMMITTEE ON HARD OF HEARING (page 1053)

COMMITTEE ON HEART DISEASE (page 1053)

COMMITTEE ON INFANTILE PARALYSIS—No written report.

COMMITTEE ON MENTAL HEALTH—No written report.

COMMITTEE ON SCHOOL HEALTH AND PHYSICAL EDUCATION (page 1061)

COMMITTEE ON TRAFFIC SAFETY (page 1062)

COMMITTEE ON TUBERCULOSIS (page 1063)

COMMITTEE ON VENEREAL DISEASE (page 1063)

REPORT OF REFERENCE COMMITTEE ON HYGIENE AND PUBLIC HEALTH

DR. O. T. SCAMAHORN, chairman, presented the following report, which was adopted:

The committee met on October 19 at 9 a. m., with all members present.

The Reference Committee on Hygiene and Public Health had for consideration the report of the Committee on Industrial Health with the exception of the third paragraph which was referred to another committee. The portion of this report referred to this committee was approved, and I move that this portion be accepted.

The report of the Committee on Cancer, on page 170, was accepted as printed in the handbook. I move that this part of the report of this committee be accepted.

The report of the Committee on Chronic Illness, page 171, was passed, but we would like to add that following item B, under 5, (page 174), it was thought that in this survey of county homes that care for the chronically ill should be put on a form approved by a previous committee so that it will reveal the true status of institutional care of the chronically ill. This information should form a basis for future improvement of such care. I move that this portion of the report of the committee be accepted.

The report of the Committee on Conservation of Vision, page 178, was accepted as printed in the Handbook. I move that this portion of the report of the committee be accepted.

The report of the Committee on Diabetes was

accepted as printed in the Handbook. I move that this portion of the report of the committee be accepted.

The report of the Committee on Hard of Hearing page 187, was approved, with one change. Line 6, in paragraph 2, was changed to read, "the Ear, Nose, and Throat Department of Indiana University School of Medicine," instead of "the Ear, Nose and Throat Section of the Indiana State Board of Health." I move this portion of the report be accepted.

The report of the Committee on Heart Disease was approved, and we recommend its acceptance as printed in the Handbook. I move acceptance of this portion of the report.

The report of the Committee on School Health and Physical Education was accepted as printed in the Handbook, except under paragraph 3, page 204, we would like to emphasize the sound nutritional program in the growth and health of the child. I move acceptance of this section of the report.

The report of the Committee on Traffic Safety is approved as printed in the Handbook. I move acceptance of this portion of the report.

The report of the Committee on Tuberculosis was accepted with the exception that the reference committee would like to call attention to the last two paragraphs. We believe these should be deleted because the Tuberculosis Committee has said that the regulation imposed by the law is impractical and that the matter of passes for active patients should be left to the discretion of the attending physician and we believe that the law is practical. I move acceptance of this portion of the report.

The report of the Committee on Venereal Disease was accepted as printed in the Handbook. I move acceptance of this portion of the report.

The Committees on Foot Hygiene, Infantile Paralysis and Mental Health submitted no reports.

The chairman wishes to thank the members of this reference committee for their cooperation in considering the above reports.

MATTERS REFERRED TO THE REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

The following matters were referred to the Reference Committee on Amendments to Constitution and Bylaws. All reports will be found on the pages indicated in the October 1953, Vol. 46, Number 10, JOURNAL of the Indiana State Medical Association. Supplemental reports and resolutions introduced before the House and referred to this committee are printed herewith.

REPORT OF COMMITTEE ON CONSTITUTION AND BYLAWS (page 1022) and the following

supplementary report of the committee, presented by Dr. William H. Garner, chairman:

Mr. President and Members of the House:

Your committee on Constitution and By-laws has had called to its attention several matters which it was felt should be clarified by this House. As we all realize, as time progresses, conditions change necessitating a constant review of our Constitution and By-laws to ascertain that it provides for the business of the day.

For example, it was found that nowhere, does the By-laws or the Constitution provide for the filling of a vacancy in the Council created by death or resignation of a Councilor. We have prepared an amendment providing for such a situation.

For several years now this House has been operating with a Reference Committee on Prepaid Insurance, yet no such Reference Committee is provided for in the By-laws.

Since the writing of the present By-laws, the type of business being conducted by this House has expanded and the definitions of the matters to be referred to certain Reference Committees are today in most cases obsolete. We feel, therefore, that changes should be made so business may be referred to the various Reference Committees by title.

The House has authorized the creation of a Section on Preventive Medicine and Public Health, yet the resolution creating this section did not provide for including it in the list of Sections as published in the By-laws.

You also saw fit to elevate the Special Committee on Rural Health to a Standing Committee on Rural Health, yet the resolution doing this did not provide for including the Committee on Rural Health in the listing of Standing Committees of this Association.

Your committee feels this House should consider amending the By-laws to provide for meetings of the House of Delegates prior to the official opening of the Annual Convention.

While it is too early at this moment for any one to have formed a definite opinion, comments heard are to the effect that the idea of holding the House session such as we are doing tonight is a fine thing as it not only gives the various Reference Committees more time to do their work, but even better, it allows the members of this Association, and the members of this House, sufficient time to appear before the Reference Committee to express their views and also will permit better attendance at the regular scientific meetings of the Convention.

The change being proposed in the By-laws covering this point is not one of mandatory wording, but only permissive, in case it is the desire to continue our meetings on the day preceding the first regular day of the Convention. I might say, in case the above has brought a question in your

mind regarding this meeting, our attorney has ruled that this meeting is held in conformance with the By-laws inasmuch as the Instructional Courses will be held tomorrow and they constitute a scientific program.

With the above explanation, your committee therefore moves the adoption of the following resolution:

RESOLVED, That Article IX of the Constitution be amended by adding an additional Section to be numbered Section 9, to read:

A vacancy resulting from any cause, except expiration of term of office, in the office of Councilor of any district shall be filled by an election by members of the Association within the Councilor District in which the vacancy occurs. A call for such election shall be issued by the executive secretary of the Association, following conference with the officers of the district organization, the call shall state the time and place of holding the election and shall be sent registered mail to the secretary, as filed in the secretary's office, of each component society within the district, at least fifteen (15) days before the date of the election. The election may be held at a special or regular meeting in which other business than the election may be transacted. Such election shall be made within ten (10) days after the secretary of the State Association shall have learned of the existence of the vacancy.

And that the Article be further amended by renumbering present Section 9 to make it Section 10.

RESOLVED, That Chapter II, Section 4, of the Bylaws be amended to read as follows:

Section 4.—The Council shall appropriate from the funds of the Association such an amount as in the discretion of the Council shall be reasonably needed for that purpose, and no commitments shall be made for expenses in excess of the amount appropriated for such Convention. The funds so appropriated shall, upon the approval of the Executive Committee, be expended at the direction of the Committee on Convention Arrangements appointed by the President for the Convention for which the appropriation is made. All money in excess of that expended for actual expenses incurred shall revert each year to the treasury of the Association.

* * * *

The above amendment is designed to place the responsibility for watching the expenditure of appropriated funds of the Association for the convention in the same manner as other funds, and to permit the establishment of a complete accounting of expenditures by the association headquarters office.

* * * *

RESOLVED, That Chapter III, Section 1 of the Bylaws be amended by adding after the letter "f" an item to read as follows:

g. Preventive Medicine and Public Health and that it be further amended by relettering item "g" to make it item "h".

RESOLVED, That Chapter IV, Section 1 of the Bylaws be amended by striking out the first sen-

tence in said Section and substituting in lieu thereof the following sentence:

"The House of Delegates may meet on the day before the date set for the beginning of the general registration of the attendance at the Annual Convention."

* * * *

RESOLVED, That Chapter IV, Section 2 of the Bylaws be amended by inserting between the present two paragraphs in said Section 2, an additional paragraph to read as follows:

"The number of Delegates to which each Component Society is entitled shall be based upon the number of members on record in the office of the Executive Secretary in good standing with current dues fully paid as of December 31 of the preceding year."

* * * *

RESOLVED, That Chapter VIII, Section 1 of the Bylaws be amended by inserting therein after the words "a Committee on Constitution and Bylaws" the following words:

"A Committee on Rural Health."

* * * *

RESOLVED, That Chapter X, Section 2 of the Bylaws be amended to read as follows:

Sec. 2—The following Reference Committees are hereby constituted to which shall be referred all matters as indicated by the titles of the committees:

- (1) Sections and Section Work
- (2) Rules and Order of Business
- (3) Medical Education and Hospitals
- (4) Legislation
- (5) Public Relations
- (6) Hygiene and Public Health
- (7) Amendments to the Constitution and By-laws
- (8) Reports of Officers
- (9) Credentials
- (10) Insurance
- (11) Miscellaneous Business

And that the section be further amended by adding the following two paragraphs without number to read:

Where a report, resolution, measure, or proposition deals with more than one subject matter, reference thereof may, in the discretion of the President, be made (a) to as many Reference Committees as are necessary to cover all subjects included therein; or (b) to only one Reference Committee which the President deems has within the scope of its reference the most important part of the matter referred.

No report of any Reference Committee shall be rejected on the ground that it covers something not included in the matters which such Committee was created to consider.

Mr. President, the Standing Committee on Constitution and By-laws moves the adoption of the resolutions as read.

REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BY-LAWS

DR. MINOR MILLER, chairman, presented the following report, which was adopted:

Your Reference Committee on Amendments to the Constitution and By-laws begs to report as follows:

That Article IX of the Constitution be amended by adding an additional section to be numbered Section 9 to read: "In the event of a vacancy occurring from any cause, except expiration of the term of office, in the office of any district councilor, the duly elected alternate councilor from the same district shall succeed to the office of councilor in that district for the unexpired term of said councilor. In the event vacancies occur in any councilor district in the offices of both councilor and alternate councilor, the vacancies shall be filled by an election by the members of the association within the councilor district in which such vacancies occur. A call for such elections shall be issued by the executive secretary of the State Association following conference with the officers of the district organization. The call shall state the time and place of holding the election and shall be sent registered mail to the county secretary as filed in the State secretary's office of each component society within the district. Such call shall be mailed within ten days after the State secretary has learned of the vacancies. The election may be held at a special or regular meeting in which other business than the election may be transacted. Such election shall be held within fifteen days after the secretary of the State Association shall have mailed such call."

And that the Article be further amended by renumbering present Section 9 to make it read Section 10.

I move the adoption of this section of the report, which will lay over for one year, with orders to be published twice in THE JOURNAL during the next year.

The other matters referred to this committee concerns amendments to the By-laws, as follows:

RESOLVED, That Chapter II, Section 4, of the Bylaws be amended to read as follows:

Section 4.—The Council shall appropriate from the funds of the Association for such an amount as in the discretion of the Council shall be reasonably needed for that purpose, and no commitments shall be made for expenses in excess of the amount appropriated for such Convention. The fund so appropriated shall, upon the approval of the Executive Committee, be expended at the direction of the Committee on Convention Arrangements appointed by the President for the Convention for which the appropriation is made. All money in excess of that expended for actual expenses incurred shall revert each year to the treasury of the Association.

Mr. President, I move adoption of this amendment to the By-laws.

RESOLVED, That Chapter III, Section 1 of the By-laws be amended by adding after the letter "f" an item to read as follows:

g. Preventive Medicine and Public Health and that it be further amended by relettering item "g" to make it item "h".

I move adoption of this amendment to the By-laws.

RESOLVED, That Chapter IV, Section 1 of the By-laws be amended by striking out the first sentence in said Section and substituting in lieu thereof the following sentence:

"The House of Delegates may meet on the day before the date set for the beginning of the general registration of the attendance at the Annual Convention."

* * * *

RESOLVED, That Chapter IV, Section 2 of the By-laws be amended by inserting between the present two paragraphs in said Section 2, an additional paragraph to read as follows:

"The number of Delegates to which each Component Society is entitled shall be based upon the number of members on record in the office of the Executive Secretary in good standing with current dues fully paid as of December 31 of the preceding year."

* * * *

RESOLVED, That Chapter VIII, Section 1 of the By-laws be amended by inserting therein after the words "a Committee on Constitution and By-laws" the following words:

"A Committee on Rural Health."

* * * *

RESOLVED, That Chapter X, Section 2 of the By-laws be amended to read as follows:

Sec. 2—The following Reference Committees are hereby constituted to which shall be referred all matters as indicated by the titles of the committees:

- (1) Sections and Section Work
- (2) Rules and Order of Business
- (3) Medical Education and Hospitals
- (4) Legislation
- (5) Public Relations
- (6) Hygiene and Public Health
- (7) Amendments to the Constitution and By-laws
- (8) Reports of Officers
- (9) Credentials
- (10) Insurance
- (11) Miscellaneous Business

And that the section be further amended by adding the following two paragraphs without number to read:

Where a report, resolution, measure, or proposition deals with more than one subject matter, reference thereof may, in the discretion of the President, be made (a) to as many Reference Committees as are necessary to cover all subjects included therein; or (b) to only one Reference

Committee which the President deems has within the scope of its reference the most important part of the matter referred.

No report of any Reference Committee shall be rejected on the ground that it covers something not included in the matters which such Committee was created to consider.

RECOMMENDATION OF COUNCIL THAT INTERIM SESSION BE DISCONTINUED

DR. ELTON R. CLARKE, chairman of the Council, presented the following recommendation:

INTERIM SESSION—The Council received the report of the Executive Committee that a survey of the county medical societies showed 43 societies, representing 1,679 members and 63 delegates, favor discontinuing the interim session of the House of Delegates; 10 societies, representing 1,132 members and 29 delegates favor continuing the interim meetings, and 27 county societies did not vote. The Council therefore recommends to the House of Delegates, by action taken at its meeting today, that the interim meetings of the House of Delegates be discontinued.

REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

DR. MINOR MILLER, chairman, presented the following report, which was adopted:

On the matters referred by the Council to the first meeting of the House of Delegates, on the matter of the Interim Session, your committee recommends the deletion of Section 7, Chapter IV, of the Bylaws of the Indiana State Medical Association. I move the adoption of this portion of the report.

RECOMMENDATION OF COUNCIL CHANGING BYLAWS ON SELECTION OF DELEGATES

DR. ELTON R. CLARKE, Council Chairman, presented the following recommendation:

Council presents for consideration of the House the following amendments to the by-laws, which were approved at its meeting today:

RESOLVED, that Chapter IV, Section 2, of the by-laws be amended by striking out last three lines of the first paragraph thereof which read as follows: "each county shall be entitled to at least one delegate to be selected by the physicians residing in such county," . . . and substituting in lieu thereof the following: "Each county shall be entitled to at least one delegate who shall be a resident of the county he represents as a delegate, and who shall be selected by the physicians residing in such county."

* * * *

RESOLVED, That Chapter IV of the By-laws be amended by adding thereto an additional section to be numbered and to read as follows:

SECTION 8. All resolutions to be presented to the House of Delegates for action shall be prepared and mailed to the Executive Secretary of the Association

so that he will receive them not later than forty-five days prior to the meeting of the House of Delegates to which the resolution will be presented for action:

Provided, that this sub-section of the by-laws may be suspended with respect to any resolution upon a two-thirds majority vote of the House of Delegates.

* * * *

REPORT OF THE REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION

DR. MINOR MILLER, chairman, presented the following report, which was adopted:

The following resolutions, containing amendments to the By-laws of the association, which were presented for consideration of the House of Delegates by the Council, were approved by the Reference Committee on Amendments to the Constitution and By-laws:

1. RESOLVED that Chapter IV, Section 2, of the Bylaws be amended by striking out the last three lines of the first paragraph thereof which read as follows: "Each county shall be entitled to at least one delegate to be selected by the physicians residing in such county," . . . and substituting in lieu thereof the following: "Each county shall be entitled to at least one delegate* and one alternate delegate who shall be a resident of the county he represents as a delegate or alternate delegate, and who shall be selected by the physicians residing in such county."

(*Italicized words have been added by the reference committee.)

2. RESOLVED that Chapter IV of the Bylaws be amended by adding thereto an additional section to be numbered and to read as follows:

SECTION 7. All resolutions to be presented to the House of Delegates for action shall be prepared and mailed to the Executive Secretary of the Association so that he will receive them not later than forty-five days prior to the meeting of the House of Delegates to which the resolutions will be presented for action:

Provided, that this sub-section of the Bylaws may be suspended with respect to any resolution upon a two-thirds majority vote of the House of Delegates.

MATTERS REFERRED TO REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

The following matters were referred to the Reference Committee on Miscellaneous Business. All reports will be found on the pages indicated in the October 1953, Vol. 46, Number 10, JOURNAL of the Indiana State Medical Association. Resolutions introduced before the House and referred to this committee are printed herewith.

COMMITTEE ON CONVENTION ARRANGEMENTS—No written report.

COMMITTEE ON CIVIL DEFENSE—entire report with exception of last paragraph, which

was referred to Reference Committee on Sections and Section Work (page 1048)

COMMITTEE ON COUNTY MEDICAL SOCIETY OFFICERS' CONFERENCE (pages 1021-1022)

COMMITTEE ON ANTI-NATIONAL HEALTH INSURANCE (page 1043)

COMMITTEE ON INDIANA INTER-PROFESSIONAL HEALTH COUNCIL (pages 1054-1055)

COMMITTEE ON MILITARY MANPOWER (page 1059)

LIAISON COMMITTEE WITH INDIANA ASSOCIATION OF LICENSED NURSING HOMES (pages 1064-1066)

LIAISON COMMITTEE WITH INDIANA DEPARTMENT OF PUBLIC WELFARE (page 1067)

REPORT OF REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

DR. JOSEPH E. DUDDING, chairman, presented the following report, which was adopted:

The Reference Committee on Miscellaneous Business submits the following recommendations on the work referred to it by the first meeting of the House of Delegates:

1. *Report of Committee on Convention Arrangements.* Dr. E. L. Fitzsimmons and his committee, and also co-chairwomen, Mrs. John Slaughter and Mrs. Charles Schneider, of the Woman's Auxiliary, have done a magnificent piece of work in arranging a most enjoyable program for the entertainment for those attending the 104th annual State Medical Association meeting.

We wish to extend the thanks of the House of Delegates to this committee and the co-chairwomen of the Woman's Auxiliary in making this a most enjoyable meeting.

We move the adoption of this part of the report.

2. *Report of the Committee on Civil Defense, with the exception of the last paragraph.* Your reference committee wishes to commend Dr. Glen Ward Lee and his committee for their very excellent and energetic work in this very important field. We urge each county medical Civil Defense Committee to cooperate to the fullest with this committee. We recommend the adoption of this part of the report.

3. *Report of Committee on County Medical Society Officers' Conference.* Your reference committee wishes to commend the Committee on County Medical Society Officers Conference for their very fine program as presented January 11, 1953. The speakers were outstanding and the program very well received. We feel that the weather man should give them a break this year. We recommend the adoption of this part of the report.

4. *Report of Anti-National Health Insurance Committee.* Your reference committee wishes to recommend that the report of this committee as published in the Handbook be rejected.

This reference committee feels there is a very definite need for this committee and that their activities be increased rather than a "standby" basis, especially in the face of the recent proposed legislation to subsidize voluntary health insurance. We move the rejection of this committee report. In other words, this report continues the committee.

5. *Report of Committee on Indiana Inter-Professional Health Council.* Your reference committee wishes to commend the members of this committee for their work in promoting better Inter-Professional relations and their work in the legislative field. We move the adoption of this part of the report.

6. *Report of Committee on Military Manpower.* Your reference committee wishes to commend this committee for their very fine work in taking care of a very difficult task. We move the adoption of this part of the report.

7. *Report of Liaison Committee with Indiana Association of Licensed Nursing Homes.* Your reference committee wishes to accept the report of this committee and commend the work of Dr. Denny and the committee on the sound advice given this group. We move the adoption of this part of the report.

8. *Report of Liaison Committee with Indiana Department of Public Welfare.* Your reference committee wishes to commend this committee for their work in bringing about better relations between the Welfare Department and the Indiana State Medical Association.

Your reference committee feels that there should be a like committee set up in each county society and difficulties which cannot be settled at a county level could be referred to the state level committee.

Your reference committee feels this Liaison Committee should be made a permanent committee of the Indiana State Medical Association. We move the adoption of this part of the report.

RESOLUTION ON DR. ARTHUR E. GUEDEL

The following resolution was introduced on behalf of the Indianapolis Medical Society by Dr.

James W. Denny, chairman of the Marion County delegation, and was referred to the Reference Committee on Miscellaneous Business:

WHEREAS, Dr. Arthur E. Guedel has gained national and international renown in the field of anesthesiology; and,

WHEREAS, Dr. Guedel has been honored by many medical organizations and has received countless awards from scientific groups in this country as well as from those in foreign lands; and

WHEREAS, Dr. Guedel has published many articles and textbooks dealing with the subject of anesthesia wherein can be found the advancements for which he was responsible in this field of medicine; and,

WHEREAS, he is a native of Indiana and a graduate of Indiana University in 1908 and, because of his achievements, has brought great credit to his state and school; now,

THEREFORE BE IT RESOLVED that the House of Delegates of the Indiana State Medical Association in convention assembled do extend to Dr. Arthur E. Guedel their warmest appreciation for his valuable contributions in the field of medical science and that this official resolution be forwarded to him as a token of the esteem in which he is held by his colleagues; and,

BE IT FURTHER RESOLVED that a copy of this resolution be forwarded to the Alumni Association of Indiana University.

REPORT OF REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

DR. J. E. DUDDING, chairman, presented the following report, which was adopted:

Resolution on Dr. Arthur E. Guedel, formerly of Indianapolis. Your reference committee moves the adoption of this report of a wonderful Hoosier.

RESOLUTION ON PROFESSIONAL LIABILITY INSURANCE PROGRAM BY THE INDIANA STATE MEDICAL ASSOCIATION

The following resolution was introduced by the Lake County delegation and was referred to the Reference Committee on Miscellaneous Business:

WHEREAS, The National Bureau of Surety and Casualty Underwriters, et al., have recently established new premium rates for professional liability insurance throughout the United States, and

WHEREAS, The rates fixed for the physicians of Indiana have been set at two to three times the former rates, and are now the highest rates in the nation with the exception of California, and

WHEREAS, The number of malpractice suits filed in Indiana, and claims paid by all insurance companies as a result of such suits is, in actual experience, among the lowest in the country,

NOW THEREFORE BE IT RESOLVED that the Indiana State Medical Association undertake an immediate study to determine:

1. The reasons for this discrepancy.
2. Means of correcting it with existing professional liability underwriters.
3. The feasibility of an Indiana State Medical Association professional liability insurance program financed by membership dues, or operated by the Association and available to members through payment of premiums into the Association or into a separate corporation established and controlled by the Association.

Adopted by the Council of the Lake County Medical Society at Gary, Indiana, September 13, 1953.

DR. MICHAEL SHELLHOUSE, Gary, presented the following amendment to the above resolution, which was referred to the Reference Committee on Miscellaneous Business:

AMENDMENT TO RESOLUTION

The delegates from the Lake County Medical Society request the House of Delegates of the Indiana State Medical Association to accept an amendment to the resolution submitted by us September 13, 1953, entitled "Resolution on Professional Liability Insurance Program by the Indiana State Medical Association."

We have been instructed by the Council of our Society at its regular meeting held October 4, 1953 to delete that portion of our original resolution which reads:

- "3. The feasibility of an Indiana State Medical Association professional liability insurance program financed by membership dues, or operated by the Association and available to members through payment of premiums into the Association or into a separate corporation established and controlled by the Association."

We move the acceptance of such amendment.

REPORT OF REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

DR. J. E. DUDDING, chairman, presented the following report, which was adopted:

Resolution on Professional Liability Insurance Program by Indiana State Medical Association

and amendment to resolution. Your reference committee, after a great amount of discussion, moves that this resolution, as amended (the amendment to delete the third paragraph dealing with the feasibility of the Indiana State Medical Association setting up a professional liability insurance company by membership dues), be adopted. We move the adoption of this part of the report.

RECOMMENDATION THAT STATE DUES BE REDUCED \$5.00

DR. ELTON R. CLARKE, chairman of the Council, presented the following recommendation, which was referred to the Reference Committee on Miscellaneous Business:

The Council, by vote taken today in its meeting, recommends to the House of Delegates that state association dues be reduced \$5.00.

REPORT OF REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

DR. J. E. DUDDING, chairman, presented the following report and moved its adoption; seconded by Dr. J. R. Doty:

Resolution by the Council to reduce the dues of the Association. Your reference committee held a lengthy discussion, heard several members of the association on the subject, and feels that it would not be wise to reduce the dues of the association at this time.

The committee feels that the Indiana State Medical Association should not endeavor to accumulate a larger and larger surplus but that a greater effort should be made to develop more and better public relations and to continue its fight against socialism in any and all means possible, and to increase the educational activities of the various committees.

The committee also feels that the present economic level is such that the dues are not a great burden to the membership at this time; however, in the not too distant future they may become a burden and that would be the logical time to lower the dues.

We move adoption of this part of the report.

DR. ROY V. MYERS, following discussion, proposed an amendment to Dr. Dudding's motion "that the recommendation presented by the Council that the dues be reduced \$5.00 be approved," which was seconded by Dr. M. C. Topping.

Discussion followed by Drs. John Palm and William C. Wright.

DR. WILLIAM C. WRIGHT moved an amendment to Dr. Myers' motion "that the dues be reduced \$10.00 instead of \$5.00."

Discussed by Drs. Gordon Thomas, P. T. Lamey,

James W. Denny, J. William Wright, Roy V. Myers and Cleon A. Nafe.

On standing vote, the motion for a \$10.00 reduction was lost.

On standing vote the motion to reduce the dues \$5.00 per year passed.

DR. DUDDING moved adoption of this section of the report, as amended; motion seconded by Dr. J. F. Ferrara, and carried.

RESOLUTION TO APPROVE SPONSORSHIP OF THE 1954 AAPS ESSAY CONTEST

DR. J. R. DOTY, Gary, presented the following resolution, which was referred to the Reference Committee on Miscellaneous Business:

WHEREAS, the Association of American Physicians and Surgeons has sponsored seven successive annual national Essay Contests for high school students on the subject "Why The Private Practice of Medicine Furnishes This Country With The Finest Medical Care," and

WHEREAS, AAPS is sponsoring its eighth successive Contest, known as the 1954 AAPS Essay Contest, and

WHEREAS, the Purdue University Opinion Poll reveals that approximately 55% of the nation's high school students approve of socialized medicine, and

WHEREAS, the issues of private practice versus socialized medicine and Human Freedom versus Socialism require a spirited fight for the impressionable young minds of the nation's youth, and

WHEREAS, there is a continuing need for educational programs like the Essay Contest because each year a new group of high school students must be enlightened, and

WHEREAS, the AAPS Essay Contest has proved to be a most effective medium to educate youth away from Socialism, and

WHEREAS, the 1953 AAPS Essay Contest was sponsored by 14 State Medical Associations and numerous county medical societies of 27 other States,

THEREFORE, BE IT RESOLVED that the Indiana State Medical Association sponsors the 1954 Contest and that all Indiana County Medical Societies be urged to sponsor the Contest at their respective county levels.

REPORT OF REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

DR. J. E. DUDDING, chairman, presented the following report, which was adopted:

12. *Resolution to approve sponsorship of the 1954 A.A.P.S. Essay Contest.* Your reference committee feels we cannot approve the sponsorship of the 1954 A.A.P.S. essay contest.

The committee feels that the Indiana State Medical Association should not sponsor another organization's project.

It does believe that the project is a worthwhile enterprise.

The reference committee felt that the proper committee might consider a similar project of the Indiana State Medical Association as a part of their educational and public relations program.

The A.A.P.S. is to be commended for their effort and any support that can be given to them or to students participating should be left to the individual physicians.

We move the adoption of this portion of the report.

Mr. Chairman, I move the adoption of this report in its entirety.

MATTERS REFERRED TO REFERENCE COMMITTEE ON PREPAID MEDICAL INSURANCE

The following matters were referred to the Reference Committee on Prepaid Medical Insurance. All reports will be found on the pages indicated in the October 1953, Vol. 46, Number 10, JOURNAL of the Indiana State Medical Association, Resolutions introduced before the House and referred to this committee are printed herewith.

COMMITTEE ON MEDICAL CARE INSURANCE (page 1058)

COMMITTEE ON PHYSICIAN-HOSPITAL RELATIONSHIPS (page 1060)

REPORT OF REFERENCE COMMITTEE ON PREPAID MEDICAL INSURANCE

DR. WILLIAM C. REED, chairman, presented the following report, which was adopted:

Four items were considered by this committee:

1. Report of Committee on Medical Care Insurance which appears on page 197 of the Handbook.

Your reference committee approves of this report, and it approves of the four recommendations except that to the second recommendation it would add the sentence, "Approval of local Medical Societies should be sought before new types of contracts are devised or introduced."

2. Report of Committee on Physician-Hospital Relationships which appears on page 201. Your reference committee approves of this report.

RESOLUTION TO BROADEN BLUE SHIELD COVERAGE

The following resolution was introduced by the Vanderburgh County delegation and was referred to the Reference Committee on Prepaid Medical Insurance:

WHEREAS, The Committee on Medical Care Insurance of the Indiana State Medical Association is now engaged in determining average fee schedules throughout the state as a preliminary

step to making recommendations on proposed new and more liberal Blue Shield Schedules, and

WHEREAS, Physicians in the strictly medical field are constantly faced with dissatisfaction on the part of their patients for the inadequate insurance coverage of their serious medical illnesses, and

WHEREAS, The medical indemnities of Blue Shield are not realistic for catastrophic medical disease and the payments are entirely out of line with the actual cost of very time-consuming medical care or specialized medical care, and a casual examination of Blue Shield statistics shows that only about one dollar out of ten is paid out for medical illness, and

WHEREAS, In catastrophic medical situations the physician may spend many hours of his time in the first few days of treatment. With the hospital facilities and therapies now available the most serious illnesses may be resolved in a week, more or less. Patients should receive additional medical protection in such cases. In the situation of a patient with severe diabetic acidosis and coma, who may require five days of hospitalization, and whose staggering hospital bill will be entirely paid, it is ridiculous that Blue Shield pays the patient only twelve dollars for medical care, and

WHEREAS, There are a number of acute, severe medical illnesses listed as follows which should receive additional protection for which objective confirmatory evidence in the nature of X-ray, electrocardiographic or laboratory findings, or a consultant's opinion should be available—

Major cerebrovascular accidents—hemorrhage, thrombosis, subarachnoid hemorrhage

Meningitis

Encephalitis

Acute coronary thrombosis

Acute pericarditis

Acute arterial occlusion

Acute left ventricular failure

Severe, persistent cardiac arrhythmias

Spontaneous pneumothorax

Massive pulmonary embolism

Status asthmaticus

Pulmonary hemorrhage, massive

Pneumonia

Massive gastro-intestinal hemorrhage

Duodenal obstruction

Acute pancreatitis

Severe diabetic acidosis—with or without coma

Severe electrolyte imbalance

Addison crises

Severe hepatitis—hepatic coma

Poisoning—drugs or chemicals

Acute psychoses

Toxemias of pregnancy

WHEREAS, In this list of illnesses it is suggested that Blue Shield pay \$25.00 for the first day of medical care and \$5.00 per day thereafter to a maximum not exceeding that for any other medical or surgical service covered, and

WHEREAS, Consideration should be given by Blue Shield to set up a method for payment of medical and surgical consultations, and minor surgical procedure on medical patients. A medical patient who requires drainage of an abscess or the amputation of a toe should be protected for both his medical and surgical expense, or at least not lose his medical coverage. Often after major surgery a patient will require medical attention for such things as heart disease and diabetes. Indemnities covering consultations should be worked out on the pattern already set up by Blue Shield, whereby a surgical assistant is paid a percentage of the surgical fee for a specified amount which he received directly from Blue Shield, and now

THEREFORE, BE IT RESOLVED, That the Committee on Medical Care Insurance of the Indiana State Medical Association be instructed by the House of Delegates to give serious consideration and study to the recommendations contained above with a view toward their ultimate adoption by Blue Shield.

REPORT OF REFERENCE COMMITTEE ON PREPAID MEDICAL INSURANCE

DR. WILLIAM C. REED, chairman, presented the following report, which was adopted:

3. Resolution to broaden Blue Shield coverage which appears on page 79.

Your reference committee approves of this resolution but recommends the following changes:

a. The third paragraph of the resolution now reads:

"WHEREAS, The medical indemnities of Blue Shield are not realistic for catastrophic medical disease and the payments are entirely out of line with the actual cost of very time-consuming medical care or specialized medical care, and a casual examination of Blue Shield statistics shows that only about one dollar out of ten is paid out for medical illness, and"

We recommend the deletion of that portion following the words "medical care", that is, "and a casual examination of Blue Shield statistics shows that only about one dollar out of ten is paid out for medical illness."

b. The fifth paragraph of the resolution reads as follows:

"WHEREAS, There are a number of acute, severe medical illnesses listed as follows which should receive additional protection for which objective confirmatory evidence in the nature of X-ray, electrocardiographic or laboratory findings, or a consultant's opinion should be available—"

We recommend that the words "listed as fol-

lows" be deleted and also the list of illnesses printed on pages 79 and 80 of the Handbook.

c. We recommend the following paragraph be deleted:

"WHEREAS, In this list of illnesses it is suggested that Blue Shield pay \$25.00 for the first day of medical care and \$5.00 per day thereafter to a maximum not exceeding that for any other medical or surgical service covered,

and this substitution be made:

"WHEREAS in relation to such illnesses it is recommended that the Board of Directors of Blue Shield be instructed to devise an equitable method of indemnity, and"

d. Under the seventh WHEREAS, we recommend deletion of the word "minor" from the first sentence and the deletion of everything after the first sentence. This paragraph now reads:

"WHEREAS, Consideration should be given by Blue Shield to set up a method for payment of medical and surgical consultations, and minor surgical procedure on medical patients. A medical patient who requires drainage of an abscess or the amputation of a toe should be protected for both his medical and surgical expenses, or at least not lose his medical coverage. Often after major surgery a patient will require medical attention for such things as heart disease and diabetes. Indemnities covering consultations should be worked out on the pattern already set up by Blue Shield, whereby a surgical assistant is paid a percentage of the surgical fee for a specified amount which he received directly from Blue Shield, and now" This section would then read:

"WHEREAS, Consideration should be given by Blue Shield to set up a method for payment of medical and surgical consultations, and surgical procedure on medical patients,"

With these changes we recommend the adoption of this resolution and recommend its acceptance.

RESOLUTION ON PAYMENT OF FEES BY INSURANCE COMPANIES DIRECTLY TO PHYSICIANS AND HOSPITALS

The following resolution was introduced by the Perry County delegation and was referred to the Reference Committee on Prepaid Medical Insurance:

WHEREAS, Doctors have for years failed to receive many of their fees for accident and health cases when insurance companies paid the patients directly instead of the doctor.

WHEREAS, Hospitals have for years often failed to receive the fees likewise intended for them in such cases when the insurance companies paid the patient directly instead of the hospital.

BE IT RESOLVED THEREFORE, That the Indiana State Medical Association make a written request to the Insurance Underwriters of America that all such settlements for health and accident

cases be paid hereafter to the doctor and hospital respectively or to the above with the patient's name attached so as to be endorsed by the patient and delivered to the doctor and/or hospital, unless the patient presents to the insurer receipted statements from said doctor and/or hospital.

BE IT FURTHER RESOLVED, That a copy of this resolution be sent to each State Medical Association urging a similar request to the Insurance Underwriters, within the earliest date possible.

The only recourse the doctor and hospital have is to have the patient sign a standardized form for assignment of charges to doctor and/or hospital.

REPORT OF REFERENCE COMMITTEE ON PREPAID MEDICAL INSURANCE

DR. WILLIAM C. REED, chairman, presented the following report, which was adopted:

4. Resolution on payment of fees by insurance companies directly to physicians and hospitals, which appears on page 83.

The reference committee is in sympathy with the problem presented in this resolution, but it is felt that by reason of the wide variety of policies offered by insurance companies, some paying the entire medical expense and others paying very little, there would be complications which would render adoption of this resolution, as written, impracticable. The committee recommends that the method of securing assignments be more fully utilized in handling this situation.

Mr. Chairman, I move the adoption of this report as a whole.

ELECTION OF OFFICERS

The following officers were elected:

President-elect: Dr. Walter L. Portteus, Franklin
Treasurer: Dr. Roy V. Myers, Indianapolis
Assistant Treasurer: Dr. Richard P. Good, Kokomo
AMA delegates, for term expiring December 31,

1955_____Dr. Alfred Ellison, South Bend
Dr. Wendell C. Stover, Boonville

AMA alternate delegates elected for term expiring
December 31, 1955...Dr. Lall G. Montgomery,
Muncie
Dr. John M. Paris, New Albany

AMA alternate delegate, elected to fill term of Dr.
Alfred Ellison, which expires December 31, 1954
Dr. Earl W. Mericle, Indianapolis

Dr. Ellison, duly elected alternate delegate for
Dr. Cleon A. Nafe, Indianapolis, was elected AMA
delegate for the two-year term beginning January
1, 1954, and ending December 31, 1955.

Dr. Mericle was elected alternate delegate to
Dr. Nafe to replace Dr. Ellison for one year beginning January 1, 1954.

Dr. Montgomery was elected alternate delegate to Dr. Ellison for the two-year term beginning January 1, 1954.

Dr. Stover was elected to succeed himself, for the two-year term beginning January 1, 1954.

Dr. Paris was elected alternate to Dr. Stover for the two-year term beginning January 1, 1954.

ADDRESS OF PRESIDENT-ELECT WALTER L. PORTEUS

The newly elected President-elect, Dr. Walter L. Portteus, was escorted to the platform, and addressed the House as follows:

Mr. President, and Gentlemen: Needless to say, words just don't come out easy this morning. I want you to know that I very deeply appreciate this honor and I am quite proud of it. All I can say, I hope and pray, with your aid and assistance, that you will be just as proud of me after my term of office as I am proud at this moment. I thank you very, very much.

PLACE OF 1955 ANNUAL CONVENTION

On invitation of Dr. Keith Hammond the House voted to hold the 1955 convention at French Lick.

RESOLUTIONS OF APPRECIATION

DR. C. S. BLACK presented the following resolution which was adopted unanimously:

I wish to direct this resolution to our newly elected president-elect. I wish to introduce a resolution of appreciation for the great services which Dr. Crimm, Dr. Howard, Jim Waggener, Miss Kribs, Miss Reid, Mrs. Grover, Bob Amick and the rest of the official family have rendered to this association during the past year and I wish to compliment Dr. Frank Ramsey on his revamping of *THE JOURNAL* and giving it a new look. It is getting to be some magazine and more beautiful all the time. And I think we owe a debt of appreciation to the Marion County Medical Society, who adjoin us in our offices in the Hume Mansur Building—Dr. Ochsner and Joe Palmer, the executive secretary, who seems to work all of the time at this convention. I think these people are in the position of the traveler down in New Mexico who was driving through the desert and saw a nice roadside restaurant, and he and his wife stopped. When they got in the place, the woman asked the manager if they had a rest room. He pointed to a Chic Sale down in the backyard. As she left, the manager asked her husband if she could take a good joke, and he said he thought she could. He said, "Why, I have that place wired up." He walked up to a speaker and spoke into it, "Say, Madam, would you mind mov-

ing over to the other hole, I am doing some painting down here." So I am going to ask you fellows to move over and let Dr. Portteus start his painting job. I wish to introduce this resolution as stated.

DR. LESTER D. BIBLER presented the following resolution which was adopted unanimously:

WHEREAS the Convention Arrangements Committee, under the able leadership of Dr. E. L. Fitzsimmons of Evansville, chairman of local arrangements, and Mrs. Mary Slaughter and Mrs. Madeline Schneider, co-chairmen of the Women's Entertainment Committee who arranged the entertainment for the ladies, and the Vanderburgh and Orange County Medical Societies, have had the responsibility as hosts for the 104th annual convention of the Indiana State Medical Association, and

WHEREAS they have performed this responsibility in their usual and commendable manner to assure the success of this session, both from a scientific and entertainment standpoint, and

WHEREAS the officers, delegates, members and guests of the Indiana State Medical Association realize the amount of time and effort necessary to arrange this meeting,

THEREFORE BE IT RESOLVED, That this House of Delegates of the Indiana State Medical Association, assembled in convention, does hereby express its sincere and heartfelt thanks and appreciation to the Orange and Vanderburgh County Medical Societies and Chairman E. L. Fitzsimmons and his committee and co-chairmen, Mrs. Mary Slaughter and Mrs. Madeline Schneider of the Women's Auxiliary, for the outstanding success of this 104th annual session of the Indiana State Medical Association.

The House adjourned, sine die, at 11:45 a. m.

EXECUTIVE COMMITTEE

October 21, 1953

Present: W. L. Portteus, M.D., chairman; James W. Denny, M.D.; W. H. Howard, M.D.; E. R. Clarke, M.D.

J. A. Waggener, executive secretary.

Upon motion of Drs. Portteus and Howard the Woman's Auxiliary was to retain the money raised from selling left-over favors in the sum of \$50.00.

Upon motion of Drs. Portteus and Clarke, Dr. James W. Denny was elected chairman of the Executive Committee.

There being no further business, the meeting was adjourned.

THE COUNCIL

(French Lick Session, 1953)

Second Meeting

The Council convened for its second meeting immediately following adjournment of the House of Delegates, Wednesday morning, October 21, 1953, in the west dining room of the French Lick Springs Hotel, with Dr. Elton R. Clarke, chairman, presiding.

Roll call showed twelve councilors, two alternate councilors, the president, the president-elect, treasurer, executive secretary and one association attorney present.

In Memoriam

The Council paused for a moment in memory of the following members who had served for many years on the Council and whose deaths had occurred during the past year: Dr. A. M. Mitchell, Terre Haute; Dr. Paul A. Garber, South Whitley; Dr. Cyrus J. Clark, Indianapolis; and Dr. M. B. Catlett, Fort Wayne.

New Business

The chairman introduced Dr. Maurice E. Glock, Fort Wayne, new councilor of the Twelfth District.

Council Reference Committees. The chairman announced the appointment of Dr. Glock as a member of the Committee on Industrial Problems, and appointed Dr. Geider chairman of the Committee on Nursing and Hospital Problems.

Membership of the Committee on Nominations for Membership on the Editorial Board will be announced later. (Following the meeting, the chairman referred this to the Council Reference Committee on Miscellaneous Business. Dr. W. U. Kennedy, chairman).

Election of two members to Committee on Inter-Professional Health Council. On motion of Dr. Blazey, the chairman was authorized to appoint the two elective members of the Inter-Professional Health Council Committee. Dr. Clarke asked that Dr. Combs, or whomever he wished to designate from the First District, and Dr. Donald E. Wood of Indianapolis, serve on this committee.

Date for 1955 meeting, French Lick. On motion of Drs. Kennedy and Blazey, the week of October 23, 1955, was set tentatively for the next French Lick convention.

Election of Executive Committee member. Dr. E. H. Clauser, Muncie, was elected a member of the Executive Committee to replace Dr. W. L. Portteus, Franklin, newly elected president-elect.

Committee on Medical Court Testimony. Dr. Doty

nominated Dr. James F. Larrabee, Hammond, for membership on this committee. Dr. Topping nominated Dr. O. O. Alexander, Terre Haute, and Dr. Olson nominated Dr. Richard Horswell, Bristol.

No further business appearing, the Council adjourned.

Minutes of Meeting of Section on General Practice French Lick Session

The Section on General Practice met at 2:00 p. m., Wednesday, October 21, 1953, in the main convention hall, French Lick Springs Hotel, French Lick, Indiana, with approximately 200 members in attendance. Speakers, introduced by Bernard E. Edwards, M.D., chairman, were: Allison E. Skaggs, John B. Hogan, and Harold L. Neff, of Black and Skaggs Associates, Inc., Battle Creek, Michigan. Their talks were followed by a question and answer period.

Minutes of the 1952 meeting of the section were read by the secretary and were accepted.

Election of officers resulted as follows:

Chairman-----Norman R. Booher, M.D.,
Indianapolis
(nominated by Elton R. Clarke, M.D.)

Vice-chairman-----Frank H. Green, Jr., M.D.,
Rushville
(nominated by Keith Hammond, M.D.)

Secretary--Russell J. Spivey, M.D., Indianapolis
(nominated by O. T. Seamahorn, M.D.)

New Business

Doctor Booher discussed the article that appeared in COLLIER'S. On motion of Dr. Lester D. Bibler, seconded by Dr. Elton R. Clarke, the section voted that this article be called to the attention of the Executive Committee of the Indiana State Medical Association. Dr. Walter L. Portteus, president-elect, suggested that ample consideration should be given the matter before getting a hurried report from the committee. Doctor Booher asked immediate attention in presenting this matter to the Executive Committee and that their judgment as to time of action be respected.

Dr. Robert B. Smallwood moved that Doctors Bibler and Booher be given a vote of thanks for the work they had done in the Committees on Medical Legislation. Motion carried.

Doctor Booher discussed the Handbook of the American Academy of General Practice which is to be used for accreditation examinations.

No further business appearing, the meeting adjourned.

THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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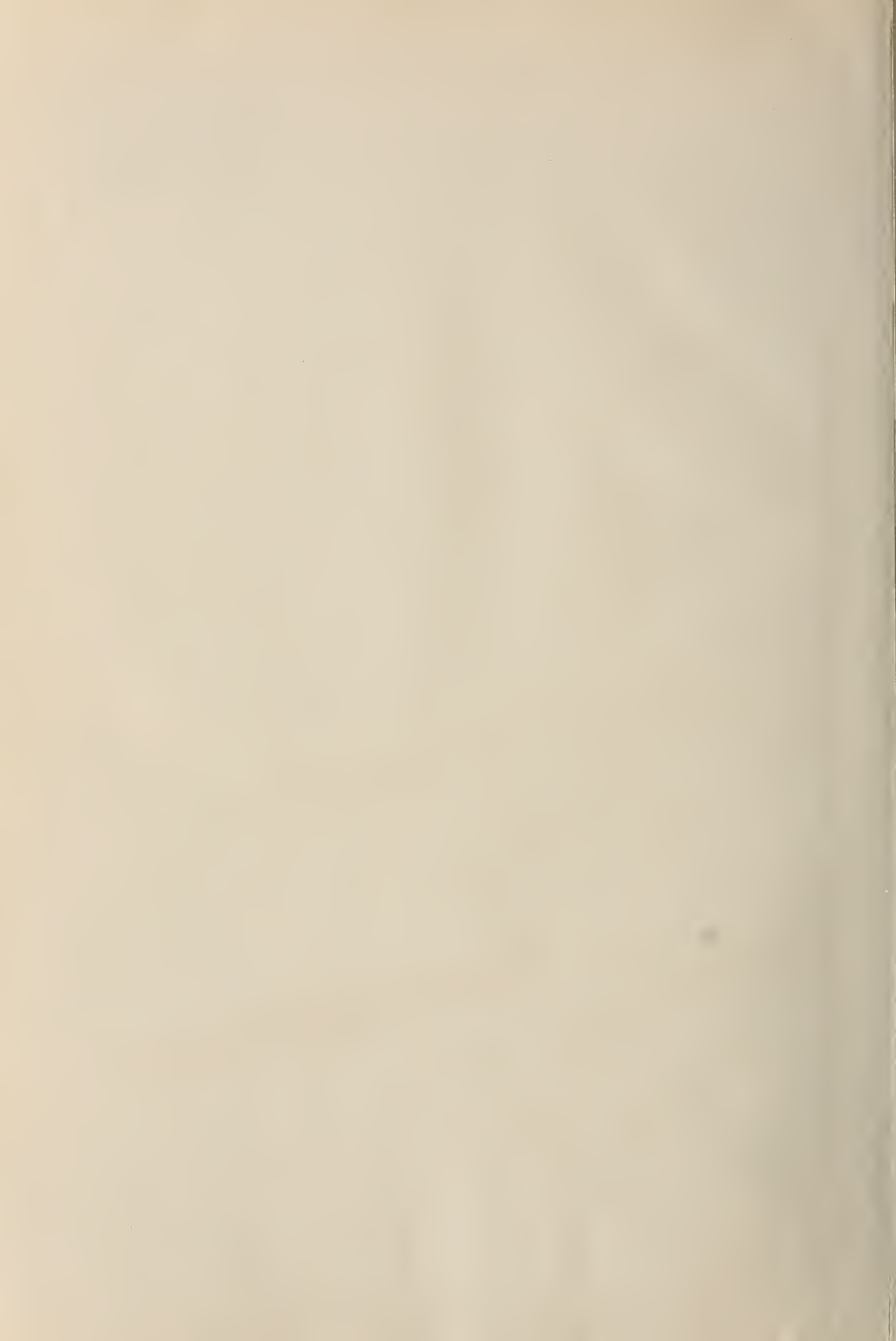
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